CCME

South Carolina External Quality Review

COMPREHENSIVE TECHNICAL REPORT FOR CONTRACT YEAR '16-17

Submitted: August 31, 2017

Prepared on behalf of the
South Carolina Department
of Health and Human Services

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 requires each State Medicaid Agency that contracts with Managed Care Organizations (MCOs) to evaluate compliance with the state and federal regulations in accordance with 42 Code of Federal Regulations (CFR) 438.358 (42 CFR § 438.358). To meet this requirement, the South Carolina Department of Health and Human Services (SCDHHS) executed a contract with The Carolinas Center for Medical Excellence (CCME), an External Quality Review Organization (EQRO), to conduct an External Quality Review (EQR) for all MCOs participating in the Healthy Connections Choices (HCC) Program.

The EQR ensures that Medicaid members receive quality health care in a system that promotes timeliness, accessibility, and coordination of all services. CCME conducted three mandatory activities: validation of performance improvement projects (PIPs), validation of performance measures (PMs), and evaluated compliance for each health plan with state and federal regulations. This report is a compilation of the 2016-2017 individual annual review findings for:

- Select Health of South Carolina (Select Health)
- Absolute Total Care (ATC)
- BlueChoice HealthPlan of South Carolina (BlueChoice)
- Molina Healthcare of South Carolina (Molina)
- WellCare of South (WellCare)
- SC Solutions (Solutions)

A. Findings Overview

An overview of the findings for each section follows. Additional details about the reviews, including strengths, weaknesses, and recommendations are included in the narrative of this report.

Administration

All of the MCOs have administrative processes, leadership, staffing, and a consistent overall approach to policies and procedures. Staffing concerns centered on leadership in the quality area, and the Director of Pharmacy does not have current licensure for BlueChoice. Additional areas needing improvement include the documentation and submission of data security audits and disaster recovery testing for Molina and WellCare. The innovative programs developed by BlueChoice for internal compliance education and by ATC, a member centered program for pregnant women with substance abuse issues, represent prudent thinking and reflects the required knowledge of their staff and member needs.

Provider Services

The Provider Services review showed that all plans rely on established programs or processes to address review areas such as credentialing/recredentialing, provider

education, network evaluation, medical record review, practice guidelines, and continuity of care. Common issues included insufficient or inconsistent information in policies, documents, and provider manuals.

The *Provider Access and Availability Study* reflects a decrease in successfully answered calls for four of the five plans from last year, and one plan (Select Health) had an unchanged rate. As a result, all plans do not meet the standard for improvement regarding Provider Access. CCME recommends that plans continue to enhance existing methods used to verify provider contact information is updated and accurate.

Member Services

Member services and member handbooks improved; all plans scored an average of 94% in this area. Member handbooks require few updates and the plans are making progress improving access to website information. Grievance files reflect improved compliance, and the plans have improved grievance policies and procedures. The health plans continue to struggle with determining when it is appropriate to direct a quality of care grievance to a medical director. All of the health plans make concerted efforts to involve members in their own health care by taking advantage of all provided services, such as case and disease management, prenatal and pregnancy care, and educational opportunities and activities in the community.

Response rate is the primary issue for the *Member Satisfaction Surveys*. All plans received response rates below the 40% target rate. For the adult surveys, three of the five plans (ATC, BlueChoice, and Molina) meet the target number of valid surveys (411) set by National Committee for Quality Assurance (NCQA). Four of the five plans achieve the target number of valid child surveys. CCME provided survey improvement recommendations to all plans, including over-sampling and posting survey announcements on the website.

Quality Improvement

PIP topics were chosen from problems and needs of the member population and practiced sound methodology and design. CCME identified two primary quality improvement (QI) issues across plans: (1) lack of clearly defined indicators and (2) unclear presentation of results and findings. Overall, the majority of PIP reports scored in the High Confidence range (69%). Only one PIP of all 13 validated scored as "Not Credible." CCME provided recommendations to the plans that will improve the documentation of PIPs and assist in verifying that the elements of protocol validation are met in subsequent reviews.

To evaluate the accuracy of the PMs reported, CCME uses the *Centers for Medicare & Medicaid Services (CMS) Protocol, Validation of Performance Measures*. This validation method balances the subjective and objective parts of the review, outlines a review process that is fair to the plans, and provides the State information about how each plan is operating. All plans are using a Healthcare Effectiveness Data and Information Set

(HEDIS®) certified vendor or software to collect and calculate the measures. All five MCOs CCME reviewed are fully compliant.

Utilization Management

Each of the health plans has developed Utilization Management (UM) Program descriptions and policies that describe UM requirements and processes. For each of the MCOs, CCME noted UM documentation inconsistencies, errors, and incomplete information; however, the plans can correct these findings easily.

Four of five plans developed and implemented preferred provider programs to meet SCDHHS Contract requirements. WellCare's program to identify high performing physicians/groups results in financial rewards but does not offer unique authorization arrangements based on improvements in quality as required by the SCDHHS Contract.

Review of UM approval and denial files reflect proper staff handling of authorization processes. Notice of action letters are written in appropriate language and contain required information; however, CCME encountered occasional findings of inappropriate acronyms or abbreviations in denial letters.

As noted in previous review cycles, appeals processes and requirements documentation continue to be problematic for all of the health plans. CCME's review of appeal files revealed that appeals are handled properly and within contractual requirements; however, CCME noted minor issues with timeliness in mailing acknowledgement and resolution letters. BlueChoice received a score of "Not Met" due to an uncorrected deficiency related to appeals from the previous EQR.

The MCOs' Case Management programs are well-established and file reviews confirm appropriate processes are conducted to meet member needs.

The plans demonstrated appropriate use of over- and underutilization data to inform UM program revisions.

Delegation

Each of the MCOs delegates some functions to entities outside of the health plan. Plans are accountable to SCDHHS, must ensure services provided are of high quality, and that delegated entity performance meets all the standards expected of the health plan as if the plan performs the functions itself. CCME's review of plan Delegation confirmed delegation agreements include: contract requirements; policies that guide staff in initial delegation process, monitoring, and annual oversight functions; appropriate tools used for conducting oversight; and corrective action plans address substandard performance.

The standards for Delegation were 100% "Met" by four of five plans. WellCare received one score of "Partially Met" because of issues related to collecting Ownership Disclosure forms and a failure to review delegate credentialing files for compliance with credentialing requirements.

State-Mandated Services

Each of the health plans provides all required core benefits, and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Programs ensure mandated services are provided to members from birth through the month of their 21st birthday. Appropriate processes are in place to monitor provider compliance with EPSDT services and immunizations.

One component of the EQR involves confirming each plan addresses and corrects all deficiencies identified in the previous review. Despite submission and approval of QI plans to address deficiencies in the previous EQR, CCME's findings indicate BlueChoice, Molina, and Select Health have not implemented all of the approved corrections.

SC Solutions

Solutions has added additional staffing in response to an increase in membership. A Compliance Officer is in place; however, Solutions does not have a Compliance Committee. Activities normally conducted in the Compliance Committee are being conducted in the Quality Management Committee. New policies may be required to address certain processes and some policies require revision to include specific South Carolina contract requirements. CCME's personnel file review identified a lack of updated driver license and driver insurance amounts required by Solutions.

Provider educational materials and information on the plan website contained outdated or inconsistent information, and Solutions does not have a policy that addresses initial or ongoing provider education.

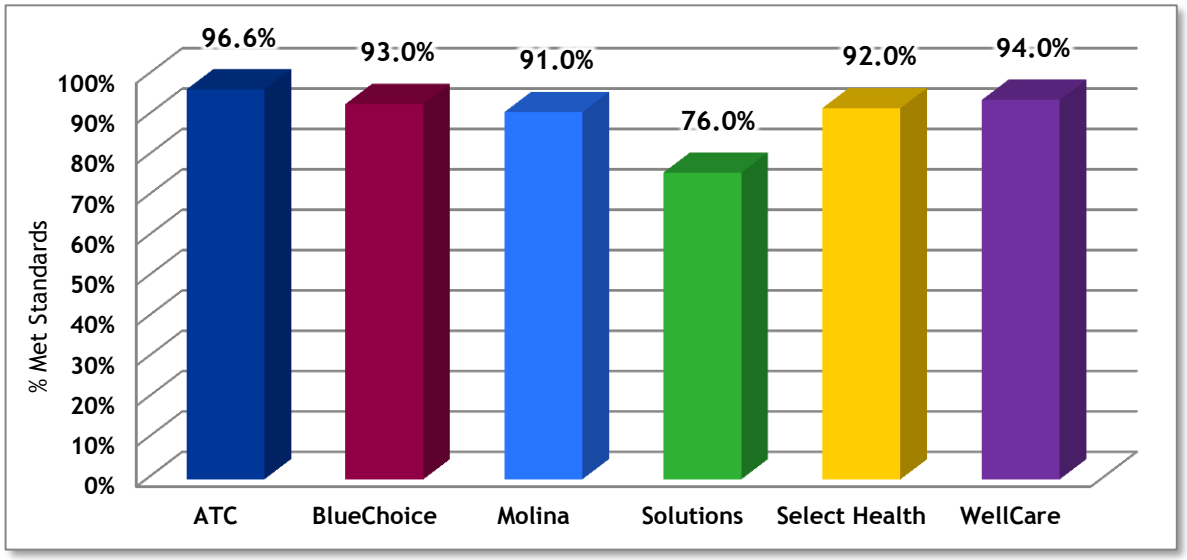
Solutions' QI program is provided at the corporate level thru Community Health Solutions of America. *Community Health Solutions' Strategic Quality Plan for 2017* was provided as evidence of a QI program description. This program description is not specific to Solutions, and it is unclear what activities or sections of the program description apply to Solutions. The 2016 and 2017 work plans lack quarterly updates and the implementation and completion dates for each activity.

Solutions policies address most care coordination and case management requirements and processes that meet those requirements; however, CCME noted errors, discrepancies, or omissions of information for specific Care Coordination requirements within the policies and other documentation. Solutions has not developed a contractually-required written policy addressing a back-up service provision plan. CCME's review of care

coordination files confirmed that, overall, Solutions is conducting appropriate care coordination and case management functions. Isolated issues with missing documentation are noted in the reviewed files, but do not appear to represent widespread process issues.

Figure 1 illustrates the percentage of "Met" standards achieved by each health plan during the 2016 – 2017 EQRs.

Figure 1: Percentage of Met Standards



B. Overall Scoring

CCME applied a numerical score (points) to each standard rating within a section to derive the overall score (percentage) for each plan. Using *CMS Protocol, External Quality Review Protocol for Accessing Compliance with Medicaid Managed Care Regulation*, the overall score is calculated based on the following:

1. Points are assigned to each rating ("Met" = 2 points and "Partially Met" = 1 point), excluding "Not Evaluated" and "Not Applicable" ratings from the calculation.
2. The total number achieved is calculated by adding the earned points together.

3. The final section score is derived by dividing the section's total points (total number achieved) by the total possible points for that section.
4. The overall score (percentage) is calculated by averaging the final section scores for the seven sections reviewed.

Table 1, Scoring Matrix, provides an overview of the final overall scores for each plan.

Table 1: Scoring Matrix

Health Plan	Score
ATC	98%
BlueChoice	95%
Molina	95%
Select Health	95%
Solutions	87%
WellCare	97%

C. Coordinated and Integrated Care Organization Annual Review

CCME assessed the provision of services in each county to determine network adequacy. The services reviewed are: Home Delivered Meals, Telemonitoring, Adult Day Health Care, Case Management, Respite, Personal care, Personal Emergency Response System (PERS), and Supplies. Network adequacy was examined in January, April, and July 2016. The final adequacy reports were submitted to SCDHHS in July 2016. After submitting the adequacy report to SCDHHS, a category of "Pass" or "Fail" was assigned to each county. For ATC, 76% of the counties had adequate network adequacy; for Molina, 26% of the counties had adequate network adequacy; and for Select Health, 90% of the counties had adequate network adequacy. Supplies, Personal Care, and PERS service categories were provided to enrollees sufficiently; however, all plans had issues provisioning telemonitoring services. CCME advised the plans to continue enhancing the provision of telemonitoring, adult day health care, respite care, home delivered meals, and case management to enrollees by locating providers within respective service areas

BACKGROUND

As the External Quality Review Organization (EQRO) for the South Carolina Department of Health and Human Services (SCDHHS), The Carolinas Center for Medical Excellence (CCME) conducts an External Quality Review (EQR) of each Managed Care Organization (MCO) participating in the Medicaid Managed Care Program. Federal regulations require that EQRs include three mandatory activities: validation of Performance Improvement Projects (PIPs), validation of Performance Measures (PMs), and evaluating compliance with state and federal regulations for each health plan.

Federal regulations also allow states to require optional activities that include:

- Validating encounter data
- Administering and validating consumer and provider surveys
- Calculating additional PMs
- Conducting PIPs and quality of care studies

After completing the annual review of required EQR activities, CCME submits a detailed technical report to SCDHHS and the respective health plan. This report describes the data aggregation, analysis, and how conclusions were drawn about the quality, timeliness, and access to care furnished by the plans. The report also contains the plan's strengths and weaknesses, recommendations for improvement, and the degree to which the plan addresses the Quality Improvement (QI) recommendations made during the prior year review. Annually, CCME prepares a comprehensive technical report for the State that is a compilation of the individual annual review findings.

The Comprehensive Technical Report for contract year 2016 through 2017 contains data for:

- Select Health of South Carolina (Select Health)
- Absolute Total Care (ATC)
- BlueChoice HealthPlan of South Carolina (BlueChoice)
- Molina Healthcare of South Carolina (Molina)
- WellCare of South (WellCare)
- SC Solutions (Solutions)

The EQR review tools for the plans participating in the Healthy Connections Prime Program were reviewed during this reporting period.

METHODOLOGY

The process used by CCME for the EQR activities is based on CMS protocols and includes a desk review of documents submitted by each health plan and onsite visits to each plan's office. After completing the annual review, CCME submits a detailed technical report to SCDHHS and the health plan. For a health plan not meeting requirements, CCME requires the plan to submit a QI plan for each standard not fully met. CCME also provides technical assistance to each health plan until all deficiencies are corrected.

Table 2 displays the dates CCME conducted the EQR for each health plan.

Table 2: External Quality Review Dates

Health Plan	EQR Initiated	Onsite Dates	Reports Submitted
ATC	December 2016	January 2017	February 2017
BlueChoice	March 2017	May 2017	June 2017
Molina	January 2017	March 2017	March 2017
Solutions	June 2017	August 2017	August 2017
Select Health	September 2016	October 2016	November 2016
WellCare	October 2016	December 2016	January 2017

FINDINGS

The plans were evaluated using standards developed by CCME and summarized in the tables in the sections that follow. CCME scored each standard as fully meeting a standard ("Met"), acceptable but needing improvement ("Partially Met"), failing a standard ("Not Met"), "Not Applicable," or "Not Evaluated." The tables reflect the scores for each standard evaluated during the EQR.

A. Administration

The review of the Administration section of the EQR included an evaluation of the health plans' policies and procedures, organizational structure and staffing, information systems, compliance, program integrity, and confidentiality. All health plans in South Carolina include experienced executive leadership and sufficient staffing who are capable of delivering quality Medicaid services to their enrollees. The behavioral health programs

have access to board-certified Psychiatrists; however, the health plans were advised to ensure psychiatrists are licensed in South Carolina. At the time of the review, BlueChoice had openings for a Medical Director and the Manager of Quality. In addition, the Pharmacy Director's license (Pharmacist) was not renewed as required by the SCDHHS Contract.

Compliance by all health plans is noted in the following areas:

- Policies and procedures are organized, reviewed annually, and updated as needed.
- Employees are informed when policies are changed or updated, and all employees have access to plan policies.

Claim payments are timely and meet or surpass SCDHHS Contract requirements. This means that greater than 90% of clean claims are paid within 30 days and 99% are paid within 90 days on average across all plans, surpassing SCDHHS Contract requirements.

The health plans have vigorous processes in place to identify, prevent, and correct abnormal trends in claims, billing procedures, and suspicion of fraud, waste, and abuse (FWA). These include automatic audits, data mining, post-payment reviews, and profiling physicians.

Compliance Programs and policies and procedures developed by all the health plans demonstrate an understanding of state and federal requirements for Compliance and Program Integrity (PI). Plans conduct and track new and existing employee annual compliance training. All employees are required to sign confidentiality agreements, attest to compliance with business ethics and the organizations' Code of Conduct. Health Insurance Portability and Accountability Act (HIPAA) training is conducted prior to employees receiving access to any Protected Health Information (PHI), although this is not documented policy for WellCare. Policies are in place for all plans to ensure appropriate release of medical information, including consent. Molina and WellCare have inconsistencies in Compliance Committee membership listings that can be easily corrected. Compliance committees have direct access to the Board of Directors and Chief Executive Officers. BlueChoice needs to update the FWA information on its website, making it easier for members to locate.

The MCOs continue to innovate and develop programs to address member and employee needs. ATC is developing a new program to address the growing problems associated with substance abuse in pregnant women. BlueChoice has developed two quarterly newsletters that increase staff awareness of compliance issues. One is focused on Compliance, Fraud, Waste, and Abuse and the other on PHI data and confidentiality. Select Health offers to connect members with limited English proficiency to reading assistance programs and covers the cost of General Educational Development (GED) tests.

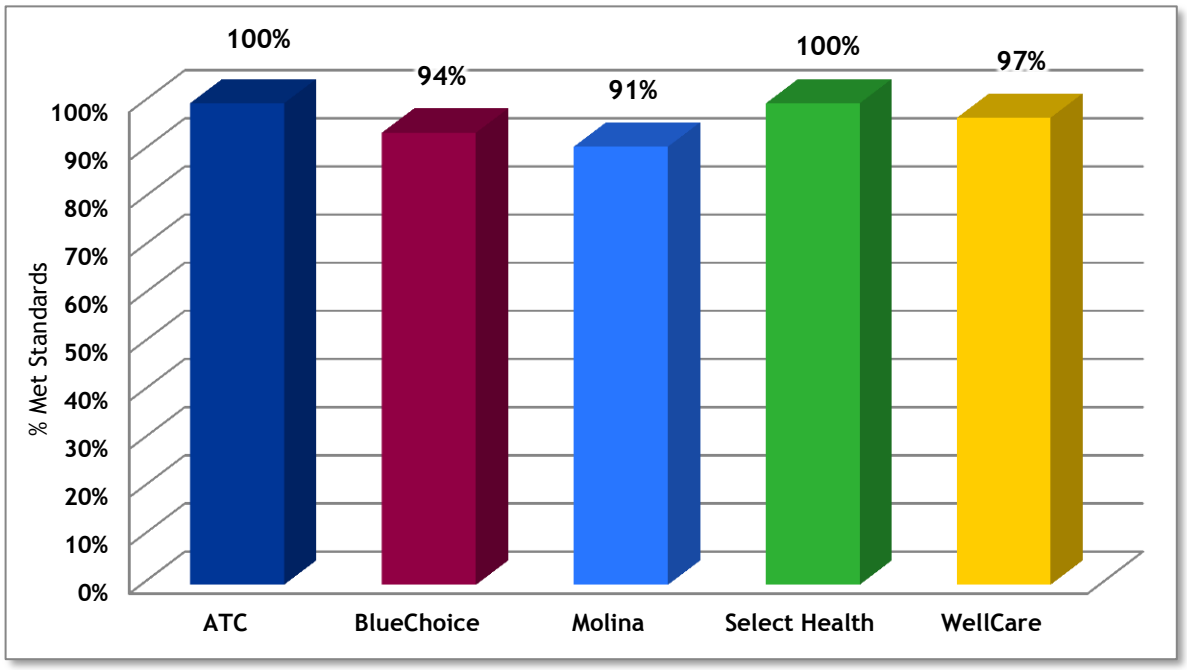
ATC and Select Health achieved "Met" scores for 100% of the standards in the Administration section. Other plan ranged from 91-97%.

Information Systems Capabilities Assessment

Data security is a high priority for the health plans, although CCME identified a few weaknesses in this area. WellCare had a security audit performed; however, documentation of a corrective action plan and actions taken to address identified problems were not submitted for review during the EQR. The health plans are required to conduct disaster recovery/business continuity plan testing to verify the plan can remain accessible and functioning following a natural or other type of disaster. The plan is tested to validate the processes in place perform as expected and any weaknesses are addressed in a corrective action by the plan. Molina did not submit documentation describing testing, testing results, or revisions made to the plan based on testing.

An overview of the "Met" scores for Administration is illustrated in *Figure 2, Administration*.

Figure 2: Administration



An overview of the scores for the Administration section is illustrated in *Table 3, Administration Comparative Data*.

Table 3: Administration Comparative Data

Standard	ATC	BlueChoice	Molina	Select Health	WellCare
General Approach to Policies and Procedures					
The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly	Met	Met	Met	Met	Met
Organizational Chart / Staffing					
The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles: Administrator (CEO, COO, Executive Director)	Met	Met	Met	Met	Met
Chief Financial Officer	Met	Met	Met	Met	Met
Contract Account Manager	Met	Met	Met	Met	Met
Claims and Encounter Manager/Administrator	Met	Met	Met	Met	Met
Network Management Claims/Encounter Processing Staff	Met	Met	Met	Met	Met
UM (Coordinator, Manager, Director)	Met	Met	Met	Met	Met
Pharmacy Director	Met	Not Met	Met	Met	Met
Behavioral Health Coordinator	Met	Met	Met	Met	Met
Utilization Review Staff	Met	Met	Met	Met	Met
CM Staff	Met	Met	Met	Met	Met
QI (Coordinator, Manager, Director)	Met	Met	Met	Met	Met
Quality Assessment and Performance Improvement Staff	Met	Met	Met	Met	Met
Provider Services Manager	Met	Met	Met	Met	Met
Provider Services Staff	Met	Met	Met	Met	Met
Member Services Manager	Met	Met	Met	Met	Met
Member Services Staff	Met	Met	Met	Met	Met
Medical Director	Met	Met	Met	Met	Met
Compliance Officer	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select Health	WellCare
Interagency Liaison	Met	Met	Met	Met	Met
Legal Staff	Met	Met	Met	Met	Met
Operational relationships of MCO staff are clearly delineated	Met	Met	Met	Met	Met
Operational responsibilities and appropriate minimum education and training requirements are identified for all MCO staff positions	Met	Met	Met	Met	Met
Management Information Systems					
The MCO processes provider claims in an accurate and timely fashion	Met	Met	Met	Met	Met
The MCO is capable of accepting and generating HIPAA compliant electronic transactions	Met	Met	Met	Met	Met
The MCO tracks enrollment and demographic data and links it to the provider base	Met	Met	Met	Met	Met
The MCO management information system is sufficient to support data reporting to the State and internally for MCO's QI and utilization monitoring activities	Met	Met	Met	Met	Met
The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract	Met	Met	Not Met	Met	Partially Met
The MCO has policies, procedures and/or processes in place for addressing system and information security and access management	Met	Met	Met	Met	Met
The MCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented	Met	Met	Partially Met	Met	Met
Compliance/Program Integrity					
The MCO has policies, procedures, and a Compliance Plan that are consistent with state and federal requirements to guard against fraud and abuse	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select Health	WellCare
The MCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities	Met	Partially Met	Partially Met	Met	Met
Confidentiality					
The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy	Met	Met	Met	Met	Met

Strengths

- BlueChoice has newsletters for staff addressing confidentiality and compliance. ATC is developing a member centered program for pregnant women with substance abuse issues, and Select Health offers reading assistance and a program that covers the cost of GED tests. The health plans continuously look for methods to improve patient interaction and quality of care.
- Mandatory training on business conduct, ethics, FWA, and the protection of health information privacy is conducted by all health plans during initial orientation and annually.
- *Compliance Plans* generally reflect current requirements, are reviewed regularly and updated as needed.
- Management Information Systems (MIS) and policies are in place for all MCOs that can accept and generate HIPAA compliant data exchange and submit required reports.

Weaknesses

- One health plan neglected to verify active licensure for staff that required licensure and one board-certified Psychiatrist was not licensed in South Carolina.
- Health plans failed to submit all the information to evaluate data security processes, testing, and audits to CCME.
- Compliance committee membership lists are inconsistent.

Recommendations

- Ensure health plans verify licenses are active for staff positions that require them.

- Evidence of the health plans' disaster recovery testing, results of testing, and any corrective action plan developed as a result of this testing should be well documented.
- Update listings of Compliance Committee membership for consistency across all plan materials.

B. Provider Services

CCME's review of Provider Services includes all policies and procedures; provider agreements; provider training and educational materials; provider network information including access and availability; credentialing and recredentialing; and practice guidelines. CCME's review of the credentialing/recredentialing programs reflects each plan has a comprehensive program that includes verification of established credentialing criteria and ongoing monitoring. BlueChoice, ATC, and Select Health were required to make some updates to their policies and program materials due to insufficient or inconsistent information, but the changes were minor and the correct processes are in place. All of the plans, except for ATC, received "Met" scores regarding the credentialing and recredentialing file reviews. ATC had three organizational files that did not contain proof of query of the *SC Excluded Providers List*.

All the plans have an established Credentialing Committee that is chaired by the Medical Director or Chief Medical Officer (CMO). The voting members of the committee vary with each plan but include network providers with specialties such as internal medicine, pediatrics, chiropractic, surgery, pulmonology, OB/GYN, dental, cardiology, psychiatry, family medicine, and hematology/oncology. Each committee has an established quorum that defines the decision-making process. Select Health and WellCare have outdated Credentialing Committee membership lists that do not reflect the current committee voting members.

Provider network adequacy is assessed by all the plans through geographic (GEO) Access reports and gap analysis. The GEO Access reports showed provider availability standards are measured in compliance with contract requirements; however, common issues identified between the plans relate to policies needing to update information and inconsistent information between documents. For the standard relating to provider accessibility, all of the plans except ATC received "Partially Met" scores. Select Health, WellCare, and Molina had inconsistencies or lack of information in policies, the *Provider Manual*, and provider orientation information. BlueChoice has outdated provider training orientations from 2015 on its website, and reporting provider appointment accessibility analysis was unclear regarding which standard was measured for urgent care—"within 24 hours" or "within 48 hours."

Provider education is conducted for all newly contracted providers and educational resources, and reference materials such as provider manuals, newsletters, bulletins,

forms, practice guidelines, etc. are available via a provider portal on each plan's website. Additional support is provided via call centers where representatives assist with questions, claims processing issues, education, and onsite visits conducted by provider relations staff. BlueChoice received a "Partially Met" score because of member benefit discrepancies identified between the *Provider Manual*, *Member Handbook*, and the BlueChoice website. Molina received a "Partially Met" score due to incorrect benefit information in the *Provider Manual*.

All of the plans have processes in place to review and adopt preventive health and clinical practice guidelines. The guidelines are reviewed and updated regularly and are posted on the plan websites. Processes are in place to monitor compliance with preventive health guidelines and clinical practice guidelines.

For practitioner medical record review, all the plans have policies that define acceptable standards for medical record documentation and the information is listed in the provider manuals. All plans conduct medical record reviews to assess a practitioner's compliance with the medical record documentation standards; however, WellCare received a "Partially Met" score because their medical record review assessment showed eight providers failed the review and presented no evidence that follow-up occurred for providers placed on a corrective action plan. During onsite discussion, WellCare was unsure when a provider is re-audited after being placed on corrective action. Molina received a "Partially Met" score because the *Provider Manual* does not reflect the medical record retention requirements defined in its policy.

Provider Access and Availability Study

As a part of the annual review process for all the plans, CCME performed a *Provider Access Study* focusing on primary care providers (PCPs) as dictated in *SCDHHS MCO Policy and Procedure Guide*. CCME requested and received a list of network providers and contact information for each of the health plans. From this list, CCME defined a population of PCPs for each plan and selected a statistically relevant sample of providers from each plan's population for the study. CCME attempted to contact these providers to ask a series of questions about the access that plan members to their PCP.

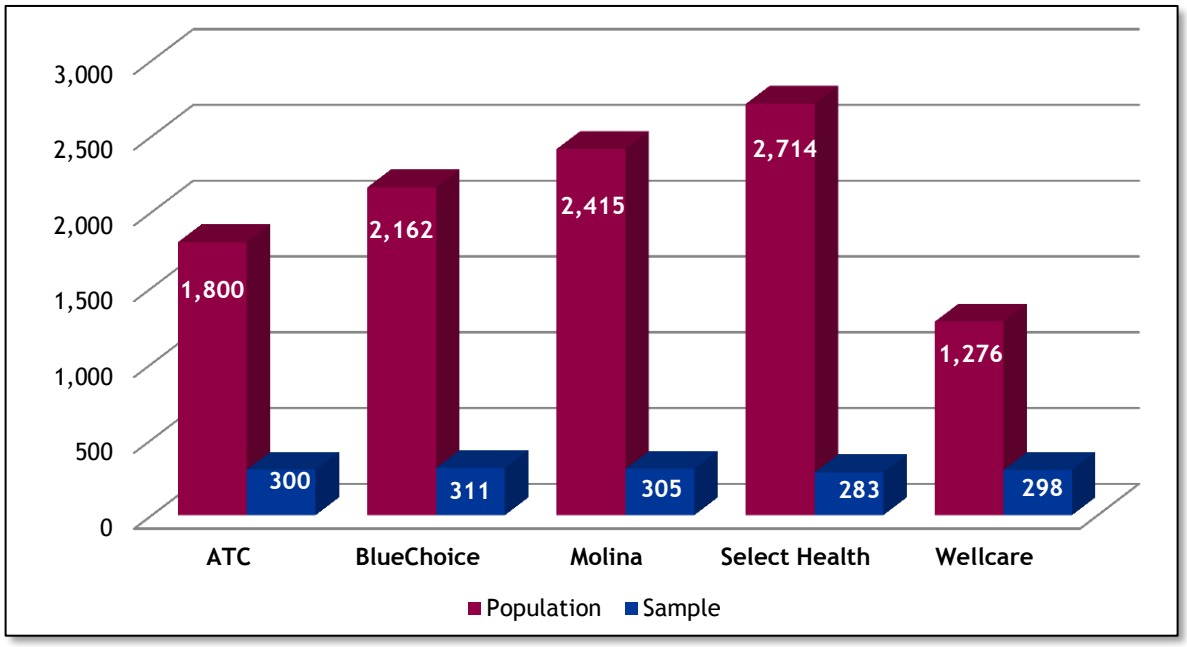
All of the plans received a score of "Not Met" for the standard requiring an improvement to the *Telephonic Provider Access Study* CCME conducted. Four plans had a decrease in the percentage of successfully answered calls, and one (Select Health) had a rate unchanged from last year. CCME encouraged the health plans to implement or maintain efforts to verify provider contact information is updated frequently.

The following charts summarize CCME's survey findings and compare the five plans surveyed during the last review cycle.

Population and Sample Size

From the five MCOs reviewed, CCME identified a total population of 10,367 PCPs. From each plan's population, CCME drew a random sample and selected a total of 1,497 providers as shown in Figure 3.

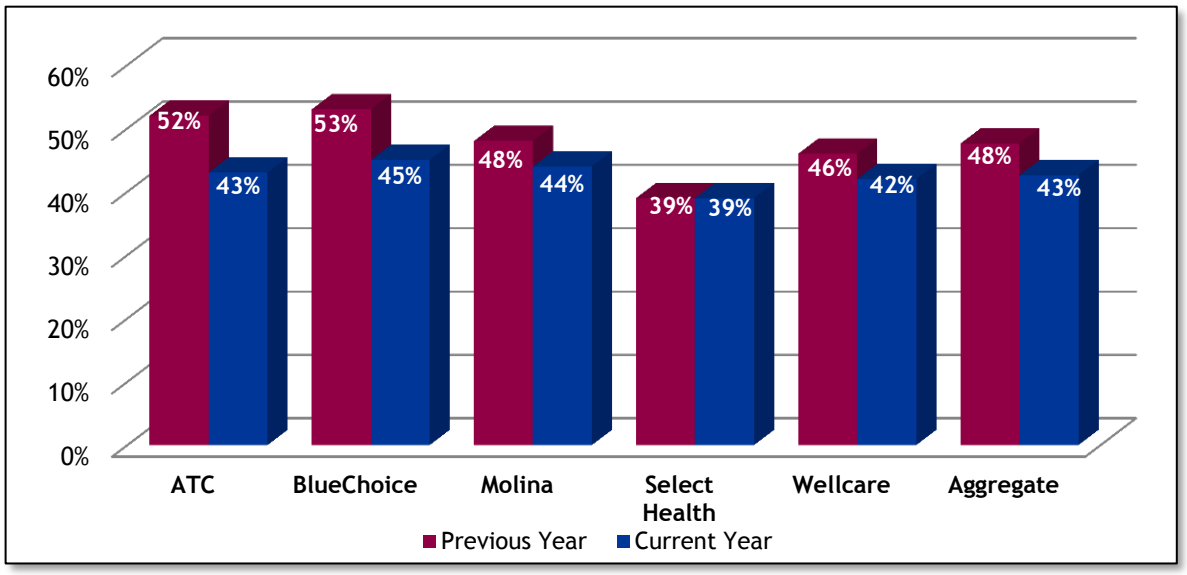
Figure 3: Population and Sample Sizes for Each Plan



Successfully Answered Calls

CCME used the telephone contact information provided by the plans and called each provider with a series of questions. In aggregate, the providers answered 43% of these calls successfully (see *Figure 4*), a 5% decrease from the previous review cycle's rate of 48%. There was one plan that received the same success rate as last year, and the other four had a decrease in the rate for successfully answered calls. The most common reason that a call was not answered is the same as last review cycle: the physician was no longer at the number (aggregate rate = 42.5%).

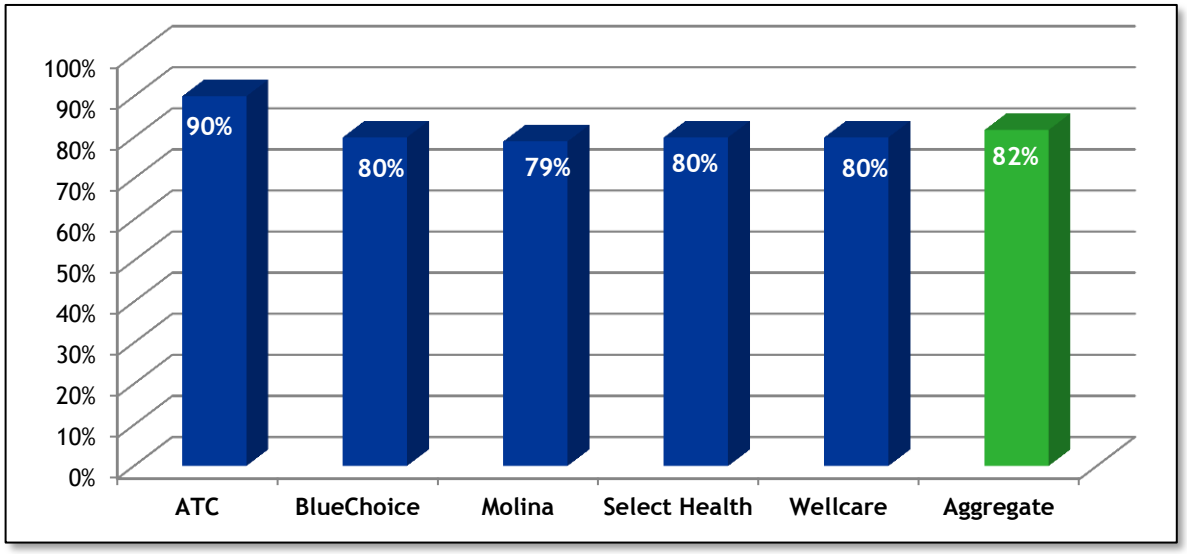
Figure 4: Percentage of Successfully Answered Calls



Currently Accepting the Plan

Of the calls successfully answered, 82% responded that the provider accepted the respective health plan. This is the same rate as last year. The percentages ranged from 79% for Molina to 90% for ATC. In the aggregate, approximately 18% of the providers reported they do not accept the plan identified. Figure 5 displays the percentage of providers that indicated they accept the plan.

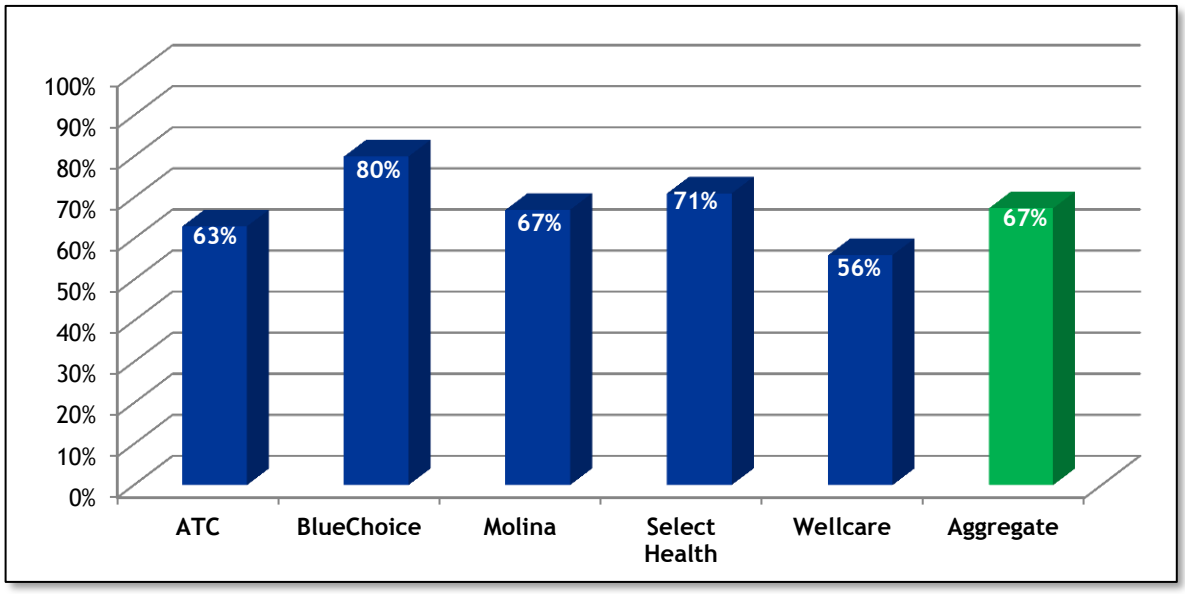
Figure 5: Percentage of Providers Accepting the Plan



Accepting Medicaid Patients

Of the providers accepting the plan, 67% responded they are accepting new Medicaid patients (see *Figure 6*). This is a 2% decrease from 69% measured during the previous review cycle. The results range from WellCare at 56% to BlueChoice at 80%.

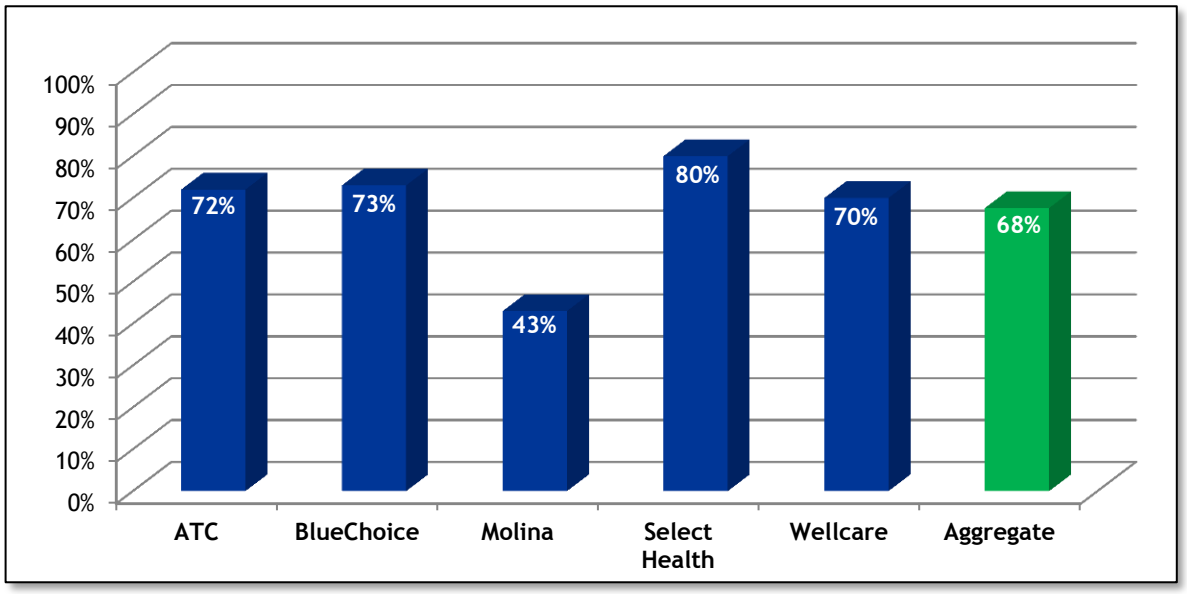
Figure 6: Percentage of Providers Accepting Medicaid Patients



Next Available Appointment

Of those accepting new Medicaid patients, when CCME asked for the next available, non-urgent appointment for the provider, 68% of all providers gave an appointment time that met the state timeframe requirements for a routine appointment (see *Figure 7*). This is a 5% increase from the prior reporting period of 63%. Select Health has the highest rate of 80% in this category, whereas Molina has the lowest rate at 43%.

Figure 7: Percentage of Providers for which the Next Available Appointment Met Contract Requirements

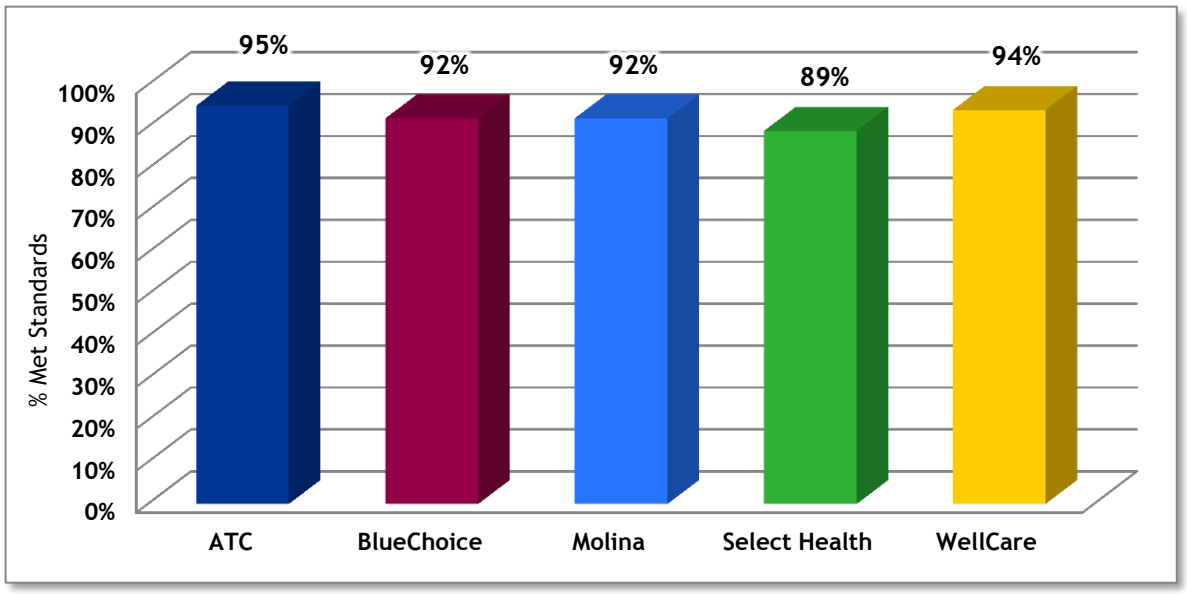


Summary of Study Findings

For all five plans, overall access to providers did not improve from the previous cycle, as indicated by the decrease in the percentage of successfully answered calls in the *Provider Access Study*. The percentage of providers that are currently accepting the plan (82%) remained unchanged from last year. The study revealed a decrease in the percentage of providers that accept Medicaid patients, but there is an increase in the percentage of providers that are able to offer an appointment within state contract requirements compared to last year. Given these findings, all plans did not meet the standard for Provider Access. As an initial step to improve beneficiary access to providers, CCME recommended that all plans update provider contact information more often and create a process whereby information is updated and validated at scheduled intervals. CCME also recommended that each plan set a percentage increase goal for year-to-year improvement (e.g., a 3% increase/improvement from the previous year).

The percentages of "Met" scores achieved by each plan for the Provider Services section of the review are illustrated in *Figure 8, Provider Services*.

Figure 8: Provider Services



An overview of the scores for the Provider Services section is illustrated in *Table 4, Provider Services Comparative Data*.

Table 4: Provider Services Comparative Data

Standard	ATC	BlueChoice	Molina	Select Health	WellCare
Credentialing and Recredentialing					
The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements	Met	Partially Met	Met	Partially Met	Met
Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO	Met	Met	Met	Partially Met	Partially Met
The credentialing process includes all elements required by the contract and by the MCO's internal policies	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select Health	WellCare
Verification of information on the applicant, including: Current valid license to practice in each state where the practitioner will treat members	Met	Met	Met	Met	Met
Valid DEA certificate and/or CDS Certificate	Met	Met	Met	Met	Met
Professional education and training, or board certification if claimed by the applicant	Met	Met	Met	Met	Met
Work history	Met	Met	Met	Met	Met
Malpractice claims history	Met	Met	Met	Met	Met
Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application	Met	Met	Met	Met	Met
Query of the National Practitioner Data Bank (NPDB)	Met	Met	Met	Met	Met
No debarred, suspended, or excluded from Federal procurement activities: Query of System for Award Management (SAM)	Met	Met	Met	Met	Met
Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline); State Excluded Provider's Report	Met	Met	Met	Met	Met
Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE)	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select Health	WellCare
In good standing at the hospitals designated by the provider as the primary admitting facility. (hospital privileges/coverage plan)	Met	Met	Met	Met	Met
Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures	Met	Met	Met	Met	Met
Ownership Disclosure Form	Met	Met	Met	Met	Met
Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures	Met	Met	Met	Met	Met
Receipt of all elements prior to the credentialing decision, with no element older than 180 days	Met	Met	Met	Met	Met
The recredentialing process includes all elements required by the contract and by the MCO's internal policies	Met	Met	Met	Met	Met
Recredentialing every three years	Met	Met	Met	Met	Met
Verification of information on the applicant, including: Current valid license to practice in each state where the practitioner will treat members	Met	Met	Met	Met	Met
Valid DEA certificate	Met	Met	Met	Met	Met
Board certification if claimed by the applicant	Met	Met	Met	Met	Met
Malpractice claims since the previous credentialing event	Met	Met	Met	Met	Met
Practitioner attestation statement	Met	Met	Met	Met	Met
Requery the NPDB	Met	Met	Met	Met	Met
Requery of the SAM	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select Health	WellCare
Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline); State Excluded Provider's Report	Met	Met	Met	Met	Met
Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG LEIE	Met	Met	Met	Met	Met
In good standing at the hospitals designated by the provider as the primary admitting facility. (hospital privileges/coverage plan)	Met	Met	Met	Met	Met
CLIA Certificate for providers billing laboratory procedures	Met	Met	Met	Met	Met
Ownership Disclosure form	Met	Met	Met	Met	Met
Site reassessment if the provider location has changed since the previous credentialing activity	Partially Met	Met	Met	Met	Met
Review of practitioner profiling activities	Met	Met	Met	Met	Met
The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues	Met	Met	Met	Met	Met
Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities	Partially Met	Partially Met	Met	Partially Met	Met
Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds	Met	Partially Met	Met	Met	Met
Adequacy of the Provider Network					
Members have a primary care physician located within a 30-mile radius of their residence	Partially Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select Health	WellCare
Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty	Met	Met	Partially Met	Partially Met	Partially Met
The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually	Met	Met	Met	Partially Met	Met
Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs	Met	Met	Partially Met	Met	Met
The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand	Met	Met	Met	Met	Met
The MCO maintains a provider directory that includes all requirements outlined in the contract	Met	Met	Met	Partially Met	Met
The MCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Met	Partially Met	Partially Met	Partially Met	Partially Met
The Telephonic *Provider Access Study* conducted by CCME shows improvement from the previous study's results	Not Met	Not Met	Not Met	Not Met	Not Met
Provider Education					
The MCO formulates and acts within policies and procedures related to initial education of providers	Met	Met	Met	Met	Met
Initial provider education includes: MCO health care program goals	Met	Met	Met	Met	Met
Billing and reimbursement practices	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select Health	WellCare
Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS	Met	Partially Met	Partially Met	Met	Met
Procedure for referral to a specialist	Met	Met	Met	Met	Met
Accessibility standards, including 24/7 access	Met	Met	Met	Met	Met
Recommended standards of care	Met	Met	Met	Met	Met
Medical record handling, availability, retention and confidentiality	Met	Met	Met	Met	Met
Provider and member grievance and appeal procedures	Met	Met	Met	Met	Met
Pharmacy policies and procedures necessary for making informed prescription choices	Met	Met	Met	Met	Met
Reassignment of a member to another PCP	Met	Met	Met	Met	Met
Medical record documentation requirements	Met	Met	Met	Met	Met
The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures	Met	Met	Met	Met	Met
Primary and Secondary Preventive Health Guidelines					
The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated	Met	Met	Met	Met	Met
The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select Health	WellCare
The preventive health guidelines include, at a minimum, the following if relevant to member demographics: Well child care at specified intervals, including EPSDTs at state-mandated intervals	Met	Met	Met	Met	Met
Recommended childhood immunizations	Met	Met	Met	Met	Met
Pregnancy care	Met	Met	Met	Met	Met
Adult screening recommendations at specified intervals	Met	Met	Met	Met	Met
Elderly screening recommendations at specified intervals	Met	Met	Met	Met	Met
Recommendations specific to member high-risk groups	Met	Met	Met	Met	Met
The MCO assesses practitioner compliance with preventive health guidelines through direct medical record audit and/or review of utilization data	Met	Met	Met	Met	Met
Clinical Practice Guidelines for Disease and Chronic Illness Management					
The MCO develops clinical practice guidelines for disease and chronic illness management of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists	Met	Met	Met	Met	Met
The MCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for MCO members to providers	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select Health	WellCare
The MCO assesses practitioner compliance with clinical practice guidelines for disease and chronic illness management through direct medical record audit and/or review of utilization data	Met	Met	Met	Met	Met
Continuity of Care					
The MCO monitors continuity and coordination of care between the PCPs and other providers	Met	Met	Met	Met	Met
Practitioner Medical Records					
The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by PCPs	Met	Met	Met	Met	Met
Standards for acceptable documentation in member medical records are consistent with contract requirements	Met	Met	Met	Met	Met
The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers	Met	Met	Met	Met	Partially Met
Accessibility to member medical records by the MCO for the purposes of QI, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract	Met	Met	Partially Met	Met	Met

Strengths

- The health plans have established processes to review and adopt preventive health and clinical practice guidelines. The plans also monitor provider adherence to the guidelines.
- Credentialing/recredentialing files are organized and contain appropriate information for all but one plan reviewed.

Weaknesses

- ATC, BlueChoice, and Select Health were required to make some updates to their credentialing/recredentialing policies and program materials due to insufficient or inconsistent information about performed queries, the collection of Disclosure of Ownership forms, and the time frame for provider site visits as a result of meeting a complaint threshold.
- ATC has three organizational files that do not contain proof of query of the *SC Excluded Providers List*.
- Select Health and WellCare have outdated Credentialing Committee membership lists that do not reflect the current voting members of the committee.
- For provider network adequacy, common issues between the plans relate to inconsistent information between documents or policies needing updated information about access standards and member-to-provider ratios. Other individual plan issues include inconsistencies between documents and the plan website.
- For the provider accessibility standard, Select Health, WellCare, and Molina have inconsistencies or lack of information related to appointment access standards in policies, the *Provider Manual*, and provider orientation information.
- BlueChoice has outdated provider training orientations from 2015 on their website, and it is unclear which standard had been measured for urgent care—"within 24 hours" or "within 48 hours" in its reporting of provider appointment accessibility analysis.
- BlueChoice received a "Partially Met" score because of member benefit discrepancies identified between the *Provider Manual*, *Member Handbook*, and the BlueChoice website. Molina received a "Partially Met" score due to incorrect benefit information in the *Provider Manual*.
- WellCare's medical record review assessment showed eight providers failed the review, and there is no evidence that follow-up took place for providers placed on a corrective action plan.
- Molina needs to update its *Provider Manual* to address medical record retention requirements defined in a policy.
- *Telephonic Provider Access Studies* conducted for all five plans by CCME demonstrate no statistical improvement to successfully answered calls made to provider offices.

Recommendations

- The plans should ensure policies, program descriptions, the *Provider Manual*, and the websites contain consistent and up-to-date information.
- The plans should ensure their Credentialing Committee membership lists are kept up-to-date with current members.

- ATC should verify organizational credentialing files contain proof of query of the *SC Excluded Providers List*.
- WellCare needs to follow-up with providers placed on corrective action due to failing a medical record review assessment.
- All plans should continue to focus on member access to providers by implementing methods to update and verify provider contact information files.

C. Member Services

CCME's Member Services review includes member education provided through the *Member Handbook*, each plan's website, and community activities. CCME also reviewed call center statistics, as well as how the health plans verify the accuracy of information provided to members when they contact the call center; the grievance process; and member satisfaction. The health plans continued improving the information provided to members in the *Member Handbook/Evidence of Coverage* documents. Member handbooks are all written in a plain and easily understood style, are available in Spanish and other languages when requested, and can be produced in audio or large print formats. The member handbooks required only minimum corrections as noted in the following list:

- WellCare has discrepancies in copayment amounts and benefit limits. The requirement for authorization to obtain out of network care and for some prescriptions was not found.
- Select Health did not inform members that they should contact the plan if they obtain other insurance or file a personal injury or worker's compensation claim. Disease management programs are inconsistently defined across plan documents and the *Member Handbook*.
- Molina provided an incomplete description of EPSDT services and little encouragement for members to comply according to schedule.
- ATC provided minimal information about Advance Directives.
- BlueChoice does not define its service area and has outdated or non-functional links in the *Member Handbook*. Members are not informed how to obtain information on community activities and no fax number for Member Services is documented.
- BlueChoice and Select Health do not include a fax number to member services; however, contacting the health plans via email is available from the websites.

BlueChoice's *Member Handbook* includes very good information on Advance Directives, Behavioral Health, and Substance Abuse services. ATC's *Member Handbook* includes encouragement and rewards for completing well-child/EPSDT visits. SCDHHS has health plans that produce excellent, high quality member handbooks for the education of

Medicaid Managed Care members. It also provides beneficial information regarding pregnancy and upcoming community events.

All of the health plans have websites that are updated frequently. The plans recognize that navigating these sites is not an easy task and members can have difficulty finding basic information. Plans are continually seeking ways to make their websites more user-friendly. The BlueChoice website contained dated materials on FWA, and several search attempts were required to find this information. All health plans have access to Member Services and 24-hour access to nurse lines are available toll-free and with teletypewriter (TTY) capabilities.

All plans audit call center calls regularly for quality and consistency. The plans monitor staffing needs continually throughout the workday to verify staffing is able to meet call demands. Call center performance standards are measured by each plan monthly and, with very rare exceptions, meet SCDHHS Contract requirements for speed of answer within 30 seconds for >80% of calls; an abandonment rate of no more than 5%; less than 2% calls receive a busy signal; and average hold times (three minutes or less). Employees across all plans receive at least quarterly updates of changes in Medicaid services and re-training occurs as needed.

Grievance policies and processes have been improving for all health plans, and generally meet SCDHHS Contract requirements. WellCare met all the standards in the grievance process. Issues noted for the other MCOs are listed below:

- Select Health has several grievance files that were not completed in a timely manner.
- BlueChoice, Molina, and Select Health each had one grievance that indicated a review by a medical director was warranted, but review did not occur prior to resolution.
- Select Health failed to include policy that denotes which types of grievances must be forwarded to a medical director for resolution. CCME also found incomplete information about grievances in the *Provider Manual*.
- ATC's grievance files indicate that the steps taken to resolve the grievance are not documented thoroughly. Policies do not include information that denotes requests to change a PCP due to dissatisfaction are handled as grievances. Policies also do not define who makes decisions about grievances involving the denial of an expedited appeal.

All of the MCOs trend and analyze grievances and many in higher volume categories drill down into each category to determine the most common types of grievances. For most plans the Billing category received the most grievances overall; however, Select Health had the most grievances in the Access and Availability category.

Scoring for the Member Services area across all plans averaged over 94%.

Member Satisfaction

As required by the contract, all five health plans conducted *Member Satisfaction Surveys*. As part of the annual EQR, CCME conducted a validation review of the *Member Satisfaction Surveys* using the protocol developed by CMS entitled, *EQR Protocol 5: Validation and Implementation of Surveys - A Voluntary Protocol for External Quality Review*. The role of the protocol is to provide the State with assurance that the results of the surveys are reliable and valid. The validation protocol is decomposed into seven activities:

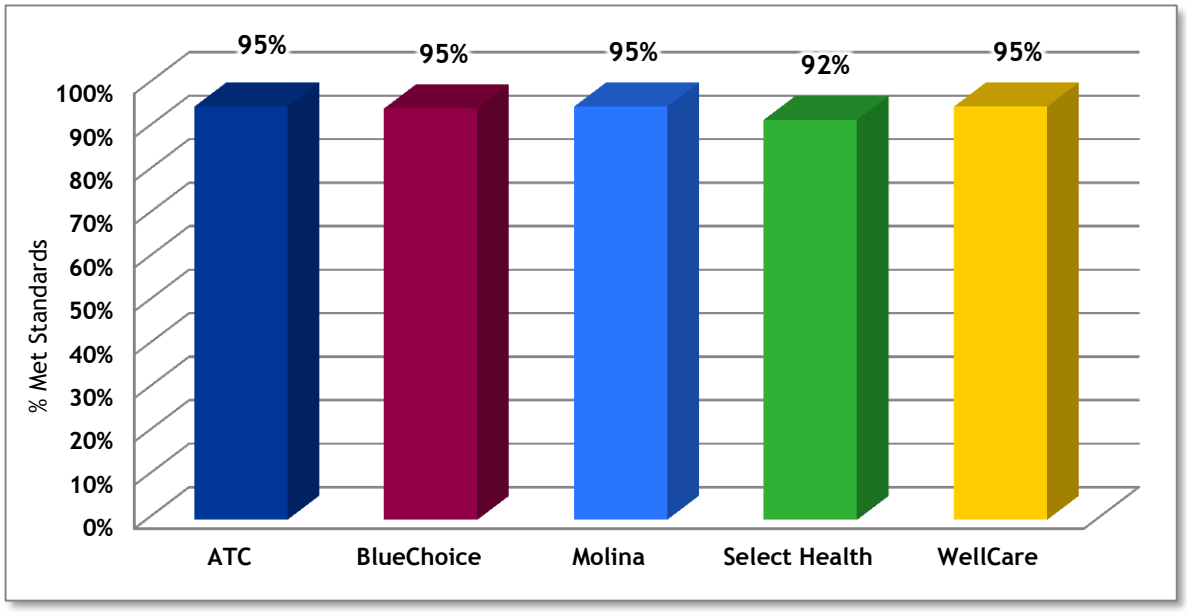
1. Review survey purpose(s), objective(s), and intended use
2. Assess the reliability and validity of the survey instrument
3. Review the sampling plan
4. Assess the adequacy of the response rate
5. Review survey implementation
6. Review survey data analysis and findings/conclusions
7. Document evaluation of the survey

All five plans used a National Committee for Quality Assurance (NCQA)-certified vendor to conduct *Member Satisfaction Surveys*. The surveys met all but one of the validation requirements. All five plans had response rates that are below the NCQA target response rate of 40.0% for both the adult and child surveys. For the adult surveys, three of the five plans (ATC, BlueChoice, and Molina) met the target number of valid surveys (n=411) set by NCQA. The adult member respondents for Select Health and WellCare do not meet the minimum of 411 responses.

For the child surveys, four of the five plans achieved the target number of valid surveys. Only WellCare had fewer than 411 valid surveys for the child surveys. The low response rates across plans can lead to response bias and results that do not represent the entire member population. CCME recommended that the plans solicit the help of the survey vendors to increase the response rates for next year's survey, incorporate reminders into the Call Center script, use the website to announce the survey, and use maximum allowed over-sampling for surveys.

Each plan's percentage of "Met" scores is demonstrated in *Figure 9, Member Services*.

Figure 9: Member Services



A comparison of the plans' scores for the standards in the Member Services section is illustrated in *Table 5, Member Services Comparative Data*

Table 5: Member Services Comparative Data

Standard	ATC	BlueChoice	Molina	Select Health	WellCare
Member Rights and Responsibilities					
The MCO formulates and implements policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities	Met	Met	Met	Met	Met
All Member Rights included	Met	Met	Met	Met	Met
Member MCO Program Education					
Members are informed in writing within 14 business days of enrollment of all benefits to which they are contractually entitled	Met	Not Met	Partially Met	Met	Partially Met

Standard	ATC	BlueChoice	Molina	Select Health	WellCare
Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network	Met	Met	Met	Partially Met	Partially Met
Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract	Met	Met	Met	Met	Met
The MCO maintains and informs members of how to access a toll-free vehicle for 24-hour member access to coverage information from the MCO, including the availability of free oral translation services for all languages	Met	Met	Met	Met	Met
Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the MCO program, with reeducation occurring as needed	Met	Met	Met	Met	Met
Materials used in marketing to potential members are consistent with the state and federal requirements applicable to enrollees and members	Met	Met	Met	Met	Met
Member Disenrollment					
Member disenrollment is conducted in a manner consistent with contract requirements	Met	Met	Met	Met	Met
Preventive Health and Chronic Disease Management Education					
The MCO enables each member to choose a PCP upon enrollment and provides assistance as needed	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select Health	WellCare
The MCO informs members about the preventive health and chronic disease management services that are available to them and encourages members to utilize these benefits	Met	Met	Met	Met	Met
The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in their recommended care, including participation in the WIC program	Met	Met	Met	Met	Met
The MCO tracks children eligible for recommended EPSDTs and immunizations and encourages members to utilize these benefits	Met	Met	Met	Met	Met
The MCO provides educational opportunities to members regarding health risk factors and wellness promotion	Met	Met	Met	Met	Met
Member Satisfaction Survey					
The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services	Met	Met	Met	Met	Met
Statistically sound methodology, including probability sampling to insure that it is representative of the total membership	Met	Met	Met	Met	Met
The availability and accessibility of health care practitioners and services	Met	Met	Met	Met	Met
The quality of health care received from MCO providers	Met	Met	Met	Met	Met
The scope of benefits and services	Met	Met	Met	Met	Met
Claim processing procedures	Met	Met	Met	Met	Met
Adverse decisions regarding MCO claim decisions	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select Health	WellCare
The MCO analyzes data obtained from the member satisfaction survey to identify quality problems	Met	Met	Met	Met	Met
The MCO implements significant measures to address quality problems identified through the member satisfaction survey	Met	Met	Met	Met	Met
The MCO reports the results of the member satisfaction survey to providers	Met	Met	Met	Met	Met
The MCO reports to the Quality Improvement Committee (QIC) on the results of the member satisfaction survey and the impact of measures taken to address those quality problems that were identified	Met	Met	Met	Met	Met
Grievances					
The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements	Met	Met	Met	Met	Met
Definition of a grievance and who may file a grievance	Met	Met	Met	Met	Met
The procedure for filing and handling a grievance	Met	Partially Met	Met	Met	Met
Timeliness guidelines for resolution of the grievance as specified in the contract	Met	Met	Met	Partially Met	Met
Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process	Partially Met	Met	Partially Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select Health	WellCare
Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract	Met	Met	Met	Met	Met
The MCO applies the grievance policy and procedure as formulated.	Partially Met	Met	Met	Partially Met	Met
Grievances are tallied, categorized, analyzed for patterns and potential QI opportunities, and reported to the QIC	Met	Met	Met	Met	Met
Grievances are managed in accordance with the MCO confidentiality policies and procedures	Met	Met	Met	Met	Met
Practitioner Changes					
The MCO investigates all member requests for PCP change in order to determine if such change is due to dissatisfaction	Met	Met	Met	Met	Met
Practitioner changes due to dissatisfaction are recorded as grievances and included in grievance tallies, categorization, analysis, and reporting to the QIC	Met	Met	Met	Met	Met
The timeliness guideline for completing a member's request to change their PCP is consistent with contract requirements	Met	Met	Met	Met	Met

Strengths

- Member handbooks produced by all health plans in South Carolina encompass the majority of state and federal requirements and include the information needed for members to access quality health care.
- The MCOs consistently meet performance goals for Member Service Call Centers.

Weaknesses

- Quality of care grievances received by the health plans are not consistently addressed by a medical director when applicable.
- Health plan staff in the grievance area lack specific direction or understanding of policies, processes, and contract requirements to address all types of grievances.
- Policies regarding the initial education of members should be updated to include timeframes as specified in the SCDHHS Contract.
- *Member Satisfaction Surveys* met all but one of the validation requirements. All five plans had response rates that are below the NCQA target response rate of 40.0% for both adult and child surveys.

Recommendations

- Grievance policy review is needed to bring the health plans into compliance with changes to federal regulations. Staff needs additional training to understand changes to policy.
- Update policies related to initial education of members to include all federal and SCDHHS Contract requirements.
- CCME recommends the plans solicit the help of the survey vendors to increase the response rates for next year's survey, incorporate reminders into the Call Center script, use the website to announce the survey, and use maximum allowed over-sampling for surveys.

D. Quality Improvement

All of the health plans are required by contract and federal regulations to have an ongoing quality assessment and performance improvement program for the services it furnishes to its members. During this contract year, all of the health plans reviewed have defined programs for measuring and improving the care and services received by members and their providers. Program descriptions include each plan's goals, objective, structure, and scope. Molina received a "Partially Met" score because its QI Program Description does not clearly reflect the monitoring conducted to assess provider compliance with the clinical and preventive practice guidelines.

Medical Directors have active roles in all plans QI Programs and Quality Improvement Committees (QICs) provide oversight and direction in assessing the appropriateness of care and service delivery provided to members. In addition, each plan assesses the effectiveness of the quality programs annually and reports the findings to its quality committees and Board of Directors for approval; however, Molina did not provide a program evaluation for 2016 because the health plan did not complete it.

Performance Measure Validation

Health plans are required to have an ongoing program of PIPs and report plan performance using HEDIS® measures applicable to the Medicaid population. To evaluate the accuracy of the PMs reported, CCME uses the *CMS Protocol, Validation of Performance Measures*. This validation protocol balances the subjective and objective parts of the review, supports a review that is fair to the plans, and provides the State information about how each plan is operating.

All five MCOs were found fully compliant. All plans are using a HEDIS® certified vendor or software to collect and calculate the measures. Plan rates for the most recent review year are reported in *Table 6, HEDIS® Performance Measure Data*. The statewide average is calculated as the average of the plan rates and shown in the last column in the following table.

Table 6: HEDIS® Performance Measure Data

Measure/Data Element	ATC	BlueChoice	Molina	Select Health	WellCare	Statewide Average
Effectiveness of Care: Prevention and Screening						
Adult BMI Assessment (aba)	77%	84%	84%	82%	72%	82%
Weight Assessment and Counseling for Nutrition & Physical Activity for Children and Adolescents (wcc)						
• BMI Percentile	59%	70%	60%	68%	54%	62%
• Counseling for Nutrition	47%	57%	47%	56%	46%	51%
• Counseling for Physical Activity	38%	48%	41%	52%	40%	44%
Childhood Immunization Status (cis)						
• DTaP	70%	70%	67%	73%	58%	68%
• IPV	86%	86%	86%	86%	74%	84%
• MMR	84%	83%	84%	87%	78%	83%
• HiB	80%	78%	80%	83%	68%	78%
• Hepatitis B	86%	84%	86%	85%	74%	83%
• VZV	85%	82%	86%	88%	78%	84%
• Pneumococcal Conjugate	68%	75%	71%	75%	58%	69%
• Hepatitis A	76%	80%	81%	82%	73%	78%
• Rotavirus	67%	72%	69%	76%	55%	68%
• Influenza	32%	35%	34%	44%	28%	35%
• Combination #2	64%	65%	62%	67%	52%	62%

Measure/Data Element	ATC	BlueChoice	Molina	Select Health	WellCare	Statewide Average
• Combination #3	60%	64%	60%	64%	50%	60%
• Combination #4	56%	61%	58%	62%	48%	57%
• Combination #5	49%	56%	51%	59%	41%	51%
• Combination #6	27%	29%	26%	38%	21%	28%
• Combination #7	47%	54%	51%	57%	40%	50%
• Combination #8	27%	29%	26%	36%	21%	28%
• Combination #9	23%	26%	23%	35%	18%	25%
• Combination #10	23%	26%	23%	33%	18%	25%
Immunizations for Adolescents (ima)						
• Meningococcal	67%	63%	64%	71%	55%	64%
• Tdap/Td	87%	85%	82%	87%	73%	83%
• Combination #1	66%	60%	62%	69%	54%	62%
• Human Papillomavirus Vaccine for Female Adolescents (hpv)	21%	16%	17%	23%	13%	18%
• Lead Screening in Children (lsc)	56%	57%	62%	67%	59%	60%
• Breast Cancer Screening (bcs)	59%	49%	NA	61%	53%	56%
• Cervical Cancer Screening (ccs)	65%	50%	59%	63%	61%	60%
Chlamydia Screening in Women (chl)						
• 16-20 Years	51%	44%	46%	49%	53%	49%
• 21-24 Years	64%	55%	62%	58%	63%	60%
• Total	55%	48%	49%	51%	55%	52%
EFFECTIVENESS OF CARE: RESPIRATORY CONDITIONS						
Appropriate Testing for Children with Pharyngitis (cwp)	70%	77%	74%	78%	76%	75%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	22%	27%	NA	33%	23%	26%
Pharmacotherapy Management of COPD Exacerbation (pce)						
• Systemic Corticosteroid	52%	49%	61%	66%	55%	57%
• Bronchodilator	81%	70%	74%	81%	75%	76%

Measure/Data Element	ATC	BlueChoice	Molina	Select Health	WellCare	Statewide Average
Medication Management for People With Asthma (mma)						
• 5-11 Years - Medication Compliance 50%	42%	47%	52%	62%	49%	50%
• 5-11 Years - Medication Compliance 75%	19%	24%	22%	35%	21%	24%
• 12-18 Years - Medication Compliance 50%	41%	47%	47%	55%	39%	46%
• 12-18 Years - Medication Compliance 75%	16%	22%	19%	30%	15%	20%
• 19-50 Years - Medication Compliance 50%	48%	61%	53%	59%	54%	55%
• 19-50 Years - Medication Compliance 75%	27%	32%	34%	36%	22%	30%
• 51-64 Years - Medication Compliance 50%	69%	72%	69%	69%	65%	69%
• 51-64 Years - Medication Compliance 75%	22%	44%	51%	50%	43%	42%
• Total - Medication Compliance 50%	44%	49%	51%	59%	47%	50%
• Total - Medication Compliance 75%	19%	24%	22%	34%	20%	24%
Asthma Medication Ratio (amr)						
• 5-11 Years	68%	79%	74%	69%	72%	73%
• 12-18 Years	54%	65%	61%	57%	65%	61%
• 19-50 Years	43%	47%	46%	50%	37%	45%
• 51-64 Years	60%	37%	47%	52%	60%	51%
• Total	59%	69%	66%	63%	65%	65%
EFFECTIVENESS OF CARE: CARDIOVASCULAR CONDITIONS						
Controlling High Blood Pressure (cbp)	44%	43%	49%	49%	39%	45%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	60%	81%	82%	73%	77%	75%
Statin Therapy for Patients With Cardiovascular Disease (spc)						
• Received Statin Therapy - 21-75 years (Male)	70%	72%	78%	76%	70%	73%
• Statin Adherence 80% - 21-75 years (Male)	60%	76%	72%	81%	50%	68%

Measure/Data Element	ATC	BlueChoice	Molina	Select Health	WellCare	Statewide Average
• Received Statin Therapy - 40-75 years (Female)	64%	76%	73%	76%	69%	72%
• Statin Adherence 80% - 40-75 years (Female)	61%	66%	66%	80%	45%	64%
• Received Statin Therapy - Total	68%	74%	75%	76%	70%	73%
• Statin Adherence 80% - Total	61%	71%	69%	81%	48%	66%
EFFECTIVENESS OF CARE: DIABETES						
Comprehensive Diabetes Care (cdc)						
• Hemoglobin A1c (HbA1c) Testing	86%	84%	91%	90%	82%	87%
• HbA1c Poor Control (>9.0%)	53%	48%	43%	50%	58%	50%
• HbA1c Control (<8.0%)	40%	45%	47%	41%	37%	42%
• HbA1c Control (<7.0%)	NA	NA	NA	30%	NA	30%
• Eye Exam (Retinal) Performed	51%	30%	50%	56%	29%	43%
• Medical Attention for Nephropathy	91%	92%	94%	92%	88%	91%
• Blood Pressure Control (<140/90 mm Hg)	43%	51%	52%	54%	45%	49%
Statin Therapy for Patients With Diabetes (spd)						
• Received Statin Therapy	55%	58%	47%	60%	54%	55%
• Statin Adherence 80%	40%	52%	56%	55%	45%	50%
Effectiveness of Care: Musculoskeletal Conditions						
• Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	59%	63%	70%	70%	67%	66%
EFFECTIVENESS OF CARE: BEHAVIORAL HEALTH						
Antidepressant Medication Management (amm)						
• Effective Acute Phase Treatment	36%	41%	41%	48%	36%	40%
• Effective Continuation Phase Treatment	23%	27%	26%	32%	22%	26%
Follow-Up Care for Children Prescribed ADHD Medication (add)						
• Initiation Phase	50%	33%	42%	41%	50%	43%

Measure/Data Element	ATC	BlueChoice	Molina	Select Health	WellCare	Statewide Average
• Continuation and Maintenance (C&M) Phase	64%	44%	56%	51%	59%	55%
Follow-Up After Hospitalization for Mental Illness (fuh)						
• 30-Day Follow-Up	62%	NA	52%	66%	8%	47%
• 7-Day Follow-Up	41%	NA	35%	42%	6%	31%
• Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	75%	79%	81%	77%	72%	77%
• Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	64%	62%	62%	74%	60%	64%
• Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	62%	100%	73%	81%	78%	79%
• Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	55%	56%	59%	70%	64%	61%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)						
• 1-5 Years	NA	20%	NA	23%	25%	23%
• 6-11 Years	18%	3%	3%	19%	21%	13%
• 12-17 Years	23%	3%	1%	27%	21%	15%
• Total	20%	3%	1%	24%	21%	14%
EFFECTIVENESS OF CARE: MEDICATION MANAGEMENT						
Annual Monitoring for Patients on Persistent Medications (mpm)						
• ACE Inhibitors or ARBs	88%	84%	89%	88%	89%	88%
• Digoxin	48%	59%	45%	48%	60%	52%
• Diuretics	89%	84%	89%	88%	89%	88%
• Total	88%	84%	89%	88%	89%	88%
EFFECTIVENESS OF CARE: OVERUSE/APPROPRIATENESS						
• **Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)**	4%	3%	3%	2%	3%	3%
• **Appropriate Treatment for Children With URI (uri)**	85%	82%	82%	85%	87%	84%

Measure/Data Element	ATC	BlueChoice	Molina	Select Health	WellCare	Statewide Average
• Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	22%	24%	24%	23%	29%	24%
• Use of Imaging Studies for Low Back Pain (lbp)	71%	71%	71%	73%	74%	72%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)						
• 1-5 Years	NA	NA	NA	0%	0%	0%
• 6-11 Years	NA	3%	3%	1%	0%	2%
• 12-17 Years	NA	3%	1%	1%	2%	2%
• Total	NA	3%	1%	1%	1%	2%
ACCESS/AVAILABILITY OF CARE						
Adults' Access to Preventive/Ambulatory Health Services (aap)						
• 20-44 Years	80%	77%	79%	83%	76%	79%
• 45-64 Years	87%	87%	88%	90%	86%	88%
• 65+ Years	50%	100%	100%	100%	100%	90%
• Total	82%	80%	82%	85%	79%	82%
Children and Adolescents' Access to Primary Care Practitioners (cap)						
• 12-24 Months	96%	96%	97%	98%	95%	97%
• 25 Months - 6 Years	86%	85%	86%	89%	84%	86%
• 7-11 Years	88%	86%	89%	92%	90%	89%
• 12-19 Years	87%	84%	88%	90%	86%	87%
Initiation and Engagement of AOD Dependence Treatment (iet)						
• Initiation of AOD Treatment: 13-17 Years	34%	39%	39%	NA	29%	35%
• Engagement of AOD Treatment: 13-17 Years	18%	26%	18%	NA	19%	20%
• Initiation of AOD Treatment: 18+ Years	36%	32%	37%	NA	36%	35%
• Engagement of AOD Treatment: 18+ Years	7%	8%	7%	NA	7%	7%
• Initiation of AOD Treatment: Total	36%	33%	37%	NA	36%	35%
• Engagement of AOD Treatment: Total	7%	9%	9%	NA	8%	8%

Measure/Data Element	ATC	BlueChoice	Molina	Select Health	WellCare	Statewide Average
Prenatal and Postpartum Care (ppc)						
• Timeliness of Prenatal Care	90%	86%	83%	92%	83%	87%
• Postpartum Care	72%	71%	66%	75%	63%	69%
Call Answer Timeliness (cat)	90%	89%	NA	85%	86%	88%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)						
• 1-5 Years	NA	100%	100%	73%	0%	68%
• 6-11 Years	70%	11%	62%	61%	74%	56%
• 12-17 Years	55%	17%	60%	58%	60%	50%
• Total	61%	19%	61%	59%	63%	53%
UTILIZATION						
Frequency of Ongoing Prenatal Care (fpc)						
• <21 Percent	2%	8%	3%	6%	6%	5%
• 21-40 Percent	2%	5%	2%	3%	3%	3%
• 41-60 Percent	5%	7%	4%	4%	5%	5%
• 61-80 Percent	13%	16%	11%	8%	15%	13%
• 81+ Percent	77%	64%	79%	79%	71%	74%
Well-Child Visits in the First 15 Months of Life (w15)						
• 0 Visits	1%	1%	1%	1%	5%	2%
• 1 Visit	2%	3%	2%	2%	3%	2%
• 2 Visits	3%	2%	2%	1%	4%	2%
• 3 Visits	5%	6%	6%	4%	4%	5%
• 4 Visits	8%	7%	11%	7%	13%	9%
• 5 Visits	21%	17%	19%	16%	19%	18%
• 6+ Visits	60%	65%	59%	69%	52%	61%
• Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	59%	65%	57%	69%	57%	61%
• Adolescent Well-Care Visits (awc)	47%	36%	43%	53%	34%	43%

* NA = measure not reported or not available

Performance Improvement Project Validation

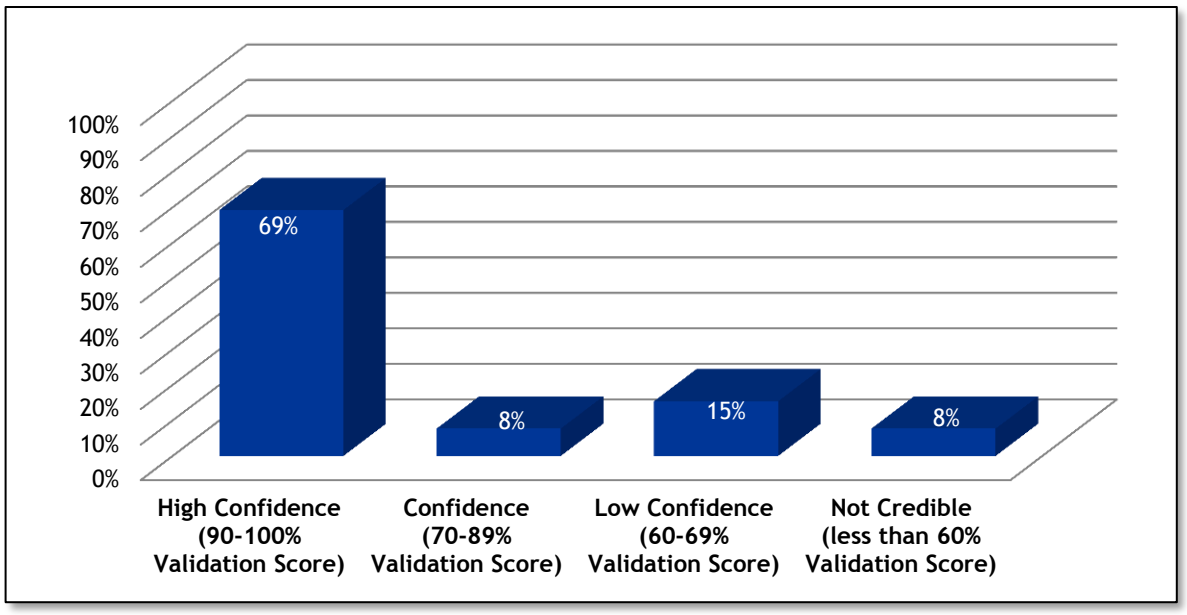
Each health plan is required to submit its PIPs (or QI projects) to CCME annually for review. CCME validates and scores the submitted projects using a CMS designed protocol that evaluates the validity and confidence in the results of each project. The 13 projects reviewed in 2016-2017 for the five plans are displayed in *Table 7, Results of the Validation of PIPs*.

Table 7: Results of the Validation of PIPs

Project	Validation Score
ATC	
• Diabetes Eye Exam	131/131 = 100% HIGH CONFIDENCE
• Member Satisfaction	125 / 125 = 100% HIGH CONFIDENCE
BlueChoice	
• Childhood Immunizations Combo 3 and Lead Screenings	125/131= 95% HIGH CONFIDENCE
• Access and Availability of Care	113/118=96% HIGH CONFIDENCE
Molina	
• Mobile Mammogram Program	96/96 = 100% HIGH CONFIDENCE
• Well Care Program	125/131 = 95% HIGH CONFIDENCE
• Provider Data Management	70/76 = 92% HIGH CONFIDENCE
Select Health	
• Comprehensive Diabetes Care	95/110= 86% CONFIDENCE
• Chlamydia Screening	42/78= 54% RESULTS NOT CREDIBLE
• Post Discharge Follow-Up for members with Asthma Exacerbation	52/82 = 65% LOW CONFIDENCE
• Coordination of Care: ER Follow-up	59/85 = 69% LOW CONFIDENCE
WellCare	
• Improving Hemoglobin A1C Testing (Clinical)	73/78 = 94% HIGH CONFIDENCE
• Child HealthCare/ Parent/Caregiver Member Satisfaction	101/106= 95% HIGH CONFIDENCE

Figure 10 displays the aggregated validation scores for the PIPs across all five measured plans.

Figure 10: Percent of Performance Improvement Projects



Issues for PIPs

CCME found two primary issues across plans: (1) lack of clearly defined indicators and (2) unclear presentation of the results and findings. Other issues include lack of barriers that are associated with interventions, lack of statistical testing when sampling is utilized, inclusion of research questions in the report, and lack of improvement in the measures of interest. CCME provided recommendations to each plan that can improve documentation for the next review cycle. In addition, each plan was referred to the *CMS Protocol, Validation of Performance Improvement Projects* as a guide for the PIP reports.

Figure 11 and Table 8 that follow provide an overview of plans' performance in Quality Improvement.

Figure 11: Quality Improvement

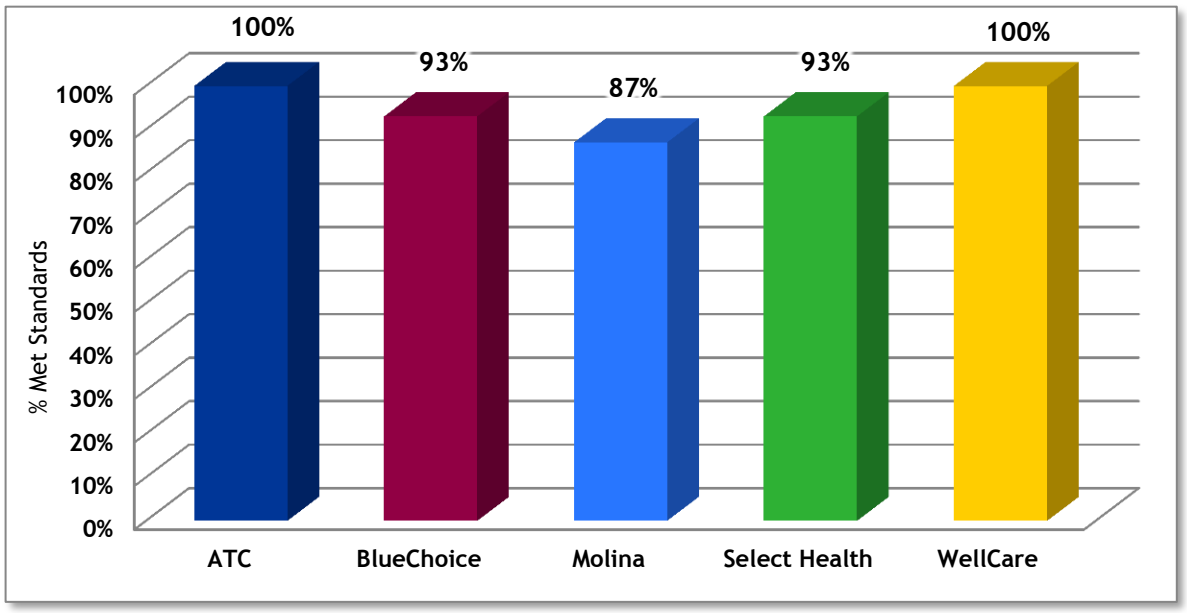


Table 8: Quality Improvement Comparative Data

Standard	ATC	BlueChoice	Molina	Select Health	WellCare
The Quality Improvement (QI) Program					
The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members	Met	Met	Met	Met	Met
The scope of the QI program includes monitoring of provider compliance with MCO wellness care and disease management guidelines	Met	Met	Partially Met	Met	Met
The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select Health	WellCare
An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s)	Met	Met	Met	Met	Met
Quality Improvement Committee (QIC)					
The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities	Met	Met	Met	Met	Met
The composition of the QIC reflects the membership required by the contract	Met	Met	Met	Met	Met
The QIC meets at regular quarterly intervals	Met	Met	Met	Met	Met
Minutes are maintained that document proceedings of the QIC	Met	Met	Met	Met	Met
Performance Measures					
Performance measures required by the contract are consistent with the requirements of the CMS Protocol, Validation of Performance Measures	Met	Met	Met	Met	Met
QI Projects					
Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population	Met	Met	Met	Met	Met
The study design for QI projects meets the requirements of the CMS Protocol, Validating of Performance Improvement Projects	Met	Met	Partially Met	Not Met	Met
Provider Participation in QI Activities					
The MCO requires its providers to actively participate in QI activities	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select Health	WellCare
Providers receive interpretation of their QI performance data and feedback regarding QI activities	Met	Met	Met	Met	Met
Annual Evaluation of the QI Program					
A written summary and assessment of the effectiveness of the QI program for the year is prepared annually	Met	Met	Met	Met	Met
The annual report of the QI program is submitted to the QIC and to the MCO Board of Directors	Met	Met	Met	Met	Met

Strengths

- The health plans met the protocol guidelines and are considered "Fully Compliant" for all HEDIS® measures.
- PIP topics are chosen based on data analysis and rationale for PIPs is justified.
- The majority of PIPs are validated as in the High Confidence range.

Weaknesses

- Molina's QI Program Description does not clearly reflect the monitoring conducted to assess provider compliance with the clinical and preventive practice guidelines.
- CCME did not receive Molina's QI program evaluation for 2016 because it was not completed by the health plan.
- Select Health's PIPs fail to meet the validation protocol requirements.

Recommendations

- Improve documentation of PIPs by including clearly defined indicators and presenting results clearly.
- Refer to *CMS Protocol, Validation of Performance Improvement Projects* for elements needed in documentation.

E. Utilization Management

Utilization Management (UM) program descriptions and policies have been developed by each MCO to describe UM requirements and processes including program structure, lines of authority, criteria used for medical necessity decision-making, timeliness requirements

for various UM processes, etc. Review of the program descriptions, policies, member handbooks, provider manuals, plan websites, and documentation reveal that although UM processes and requirements are generally well-documented, some inconsistencies, errors, and incomplete information exists. CCME discussed these anomalies with the health plans, and provided information needed to correct the issue along with references to applicable SCDHHS Contract requirements and federal regulations.

The *SCDHHS Contract, Section 8.4.2.7*, requires the health plans to develop a preferred provider program based on quality resulting in the provider becoming eligible for special considerations when requesting service authorizations. Special considerations include exemption from service authorization requirements; an expedited service authorization process; and simplified documentation requirements for the service authorization process. During the previous cycle of review, none of the plans had established a program to meet the contract requirement; however, during the current review cycle, four plans had developed and implemented preferred provider programs that meet contractual requirements. WellCare received a score of "Partially Met" for this review standard. WellCare has developed a program that identifies high performing physicians groups using quality and cost metrics that result in financial rewards; however, the program does not offer unique authorization arrangements to providers based on improvements in quality. CCME's discussions with plan staff revealed WellCare has not identified any providers who qualify for such a program.

CCME's review of utilization management approval and denial files confirmed authorization requests are handled properly, with appropriate attempts to obtain additional information when needed to render a determination. Authorizations and notifications are timely and appropriate reviewers issue denial determinations. Notice of action letters are generally written in appropriate language and contain the required information; however, BlueChoice and Molina were found to use inappropriate acronyms or abbreviations in denial letters occasionally. For BlueChoice, one notice of action letter did not clearly convey the reasoning for the denial determination. CCME offered recommendations to both health plans that could improve these findings.

As noted in previous review cycles, the area of appeals continues to be problematic for the health plans. Issues include:

- Incomplete definition of an action (Molina)
- Errors in documentation of the procedures, requirements, or timeframe for filing appeals (BlueChoice, Molina, Select Health, and WellCare)
- Incomplete information regarding which staff may deny a request for an expedited appeal (ATC)

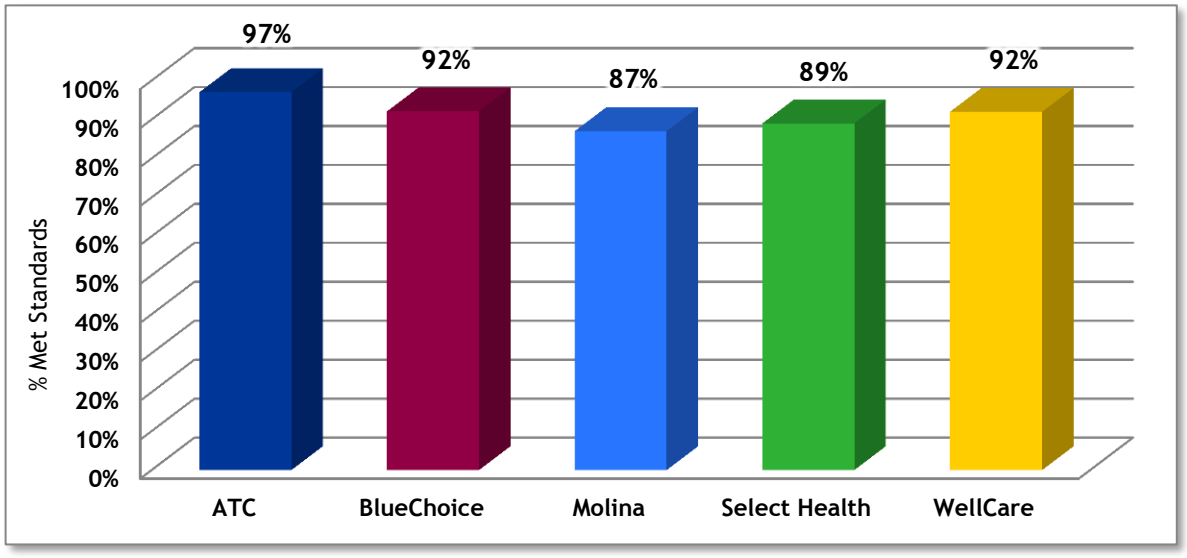
- Errors in and incomplete documentation of appeal resolution and notification timeframe requirements (BlueChoice, Molina, and Select Health)

CCME's review of appeals files revealed that, in general, files are thoroughly documented, determinations are made by appropriate reviewers, and determinations and notifications are timely. Resolution letters generally contain the required elements and are written in appropriate language. For BlueChoice, one expedited appeal was inappropriately processed under the standard appeal resolution timeframe, and one appeal resolution letter was sent outside of the required timeframe for notification of resolution. For Select Health, two appeal resolution letters were not sent within the required timeframe. For Molina, two acknowledgement letters were not sent within the required timeframe. CCME provided recommendations to the health plans that can improve these findings. Molina has implemented an internal process to review and edit appeal resolution letters prior to mailing to verify appropriate language. BlueChoice received a score of "Not Met" due to an uncorrected deficiency related to appeals from the previous EQR.

The MCOs' Case Management (CM) programs are designed and implemented to ensure comprehensive, coordinated care for members with high risk and complex needs. CCME's CM file reviews confirm appropriate processes are conducted to meet member needs. The CM files thoroughly documented and include appropriate plans of care and evidence of appropriate monitoring and follow-up.

The percentages of "Met" scores achieved by each plan for UM of the EQR are illustrated in *Figure 12, Utilization Management*.

Figure 12: Utilization Management



A comparison of all scores for the Utilization Management section is illustrated in *Table 9, Utilization Management Comparative Data*.

Table 9: Utilization Management Comparative Data

Standard	ATC	BlueChoice	Molina	Select Health	WellCare
The Utilization Management (UM) Program					
The MCO formulates and acts within policies and procedures that describe its utilization management program	Met	Met	Met	Met	Met
Structure of the program and methodology used to evaluate the medical necessity	Met	Met	Met	Met	Met
Lines of responsibility and accountability	Met	Met	Met	Met	Met
Guidelines / standards to be used in making utilization management decisions	Met	Met	Met	Met	Met
Timeliness of UM decisions, initial notification, and written (or electronic) verification	Met	Partially Met	Met	Partially Met	Met
Consideration of new technology	Met	Met	Met	Met	Met
The absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services	Met	Met	Met	Met	Met
The mechanism to provide for a Preferred Provider Program	Met	Met	Met	Met	Partially Met
The UM Program					
UM activities occur within significant oversight by the Medical Director or the Medical Director's physician designee	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select Health	WellCare
The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions	Met	Met	Met	Met	Met
Medical Necessity Determinations					
UM standards/criteria used are in place for determining medical necessity for all covered benefit situations	Met	Met	Met	Met	Met
UM decisions are made using predetermined standards/criteria and all available medical information	Met	Met	Met	Met	Met
Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations	Met	Met	Partially Met	Met	Met
UM standards/criteria are reasonable and allow for unique individual patient decisions	Met	Met	Met	Met	Met
UM standards/criteria are consistently applied to all members across all reviewers	Met	Met	Met	Met	Met
Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts	Met	Met	Met	Partially Met	Met
If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity	Met	Met	Met	Met	Partially Met

Standard	ATC	BlueChoice	Molina	Select Health	WellCare
Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations	Met	Met	Partially Met	Met	Met
UM standards/criteria are available to providers	Met	Met	Met	Met	Met
UM decisions are made by appropriately trained reviewers	Met	Met	Met	Met	Met
Initial utilization decisions are made promptly after all necessary information is received	Met	Met	Met	Met	Met
A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services	Met	Met	Met	Met	Met
All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist	Met	Met	Met	Met	Met
Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal	Met	Met	Met	Met	Met
Appeals					
The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an action by the MCO in a manner consistent with contract requirements	Met	Met	Met	Met	Met
The definitions of an action and an appeal and who may file an appeal	Met	Met	Partially Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select Health	WellCare
The procedure for filing an appeal	Met	Partially Met	Partially Met	Partially Met	Partially Met
Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case	Met	Met	Met	Met	Met
A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay	Partially Met	Met	Met	Met	Met
Timeliness guidelines for resolution of the appeal as specified in the contract	Met	Not Met	Partially Met	Met	Met
Written notice of the appeal resolution as required by the contract	Met	Met	Met	Partially Met	Met
Other requirements as specified in the contract	Met	Met	Met	Met	Met
The MCO applies the appeal policies and procedures as formulated	Met	Met	Met	Met	Met
Appeals are tallied, categorized, analyzed for patterns and potential QI opportunities, and reported to the QIC	Met	Met	Met	Met	Met
Appeals are managed in accordance with the MCO confidentiality policies and procedures	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select Health	WellCare
Case Management (CM)					
The MCO utilizes CM techniques to ensure comprehensive, coordinated care for members with complex health needs or high-risk health conditions, including populations specified in the contract	Met	Met	Met	Met	Met
Evaluation of Over/ Underutilization					
The MCO has mechanisms to detect and document under and over utilization of medical services as required by the contract	Met	Met	Met	Met	Met
The MCO monitors and analyzes utilization data for under and over utilization	Met	Met	Met	Met	Met

Strengths

- The MCOs' websites provide an abundance of information related to UM requirements, processes, forms, manuals, etc.
- The health plans' CM programs are well-developed and CM files confirm processes are employed to ensure comprehensive, coordinated care for members with complex and high-risk needs.

Weaknesses

- Discrepancies, omissions, and errors in documentation of general UM requirements, timeframes, and processes are noted across all the health plans in policies, procedures, websites, program descriptions, member handbooks, and provider manuals.
- Notice of adverse action letters for initial denials contained acronyms/abbreviations (BlueChoice and Molina) or did not clearly convey the reason for the denial decision (BlueChoice).
- WellCare's Preferred Provider Program identifies high performing physicians groups using quality and cost metrics, but does not offer unique authorization arrangements to providers based on improvements in quality as required by the contract.

- BlueChoice and WellCare documentation of inter-rater reliability processes contains errors in scoring benchmark requirements. BlueChoice and Molina documentation does not address reviewing and addressing scores below the established benchmark.
- Post-stabilization services are inadequately addressed in the *Provider Manual* (BlueChoice and Molina) and policy (Molina).
- Appeal files reflected inappropriate processing of expedited appeals under a standard appeal resolution timeframe and untimely notification of appeal resolution (BlueChoice).
- All the health plans have errors, inconsistencies, or omissions of information regarding appeals processes and requirements in policies, websites, member handbooks, provider manuals, letter templates, etc. These include, but are not limed to:
  - Definitions of terms related to appeals (Molina)
  - Appeal filing timeframes, resolution timeframes, and extensions (BlueChoice, Molina, Select Health, and WellCare)
  - Consent requirements for someone other than a member to file an appeal (Molina)
  - Staff allowed to deny requests for expedited appeals (ATC)
  - The receipt date for an appeal received outside of normal business hours (BlueChoice)
- The availability of the appeal file/documents related to the appeal (Molina, Select Health)

Recommendations

- All health plans should review and revise all documentation of UM and appeals requirements, timeframes, and processes to verify complete, correct, and consistent information is included in policies, procedures, websites, program descriptions, member handbooks, provider manuals, and documentation.
- BlueChoice and Molina should implement processes to verify initial notice of action letters are written in appropriate language, clearly convey the reason for the decision, and that appeal resolution letters are sent within contractually required timeframes.
- WellCare should implement a Preferred Provider Program that meets contract requirements.
- BlueChoice and WellCare inter-rater reliability processes and requirements should be revised to reflect the correct scoring benchmark and to include processes for follow-up when benchmark requirements are not met.

- BlueChoice and Molina should address post-stabilization services completely in provider manuals. In addition, Molina should revise policy regarding post-stabilization services to include all required information.
- BlueChoice should implement a process to identify expedited appeals to ensure all expedited appeals are processed within the appropriate resolution timeframe.

F. Delegation

The MCOs have developed policies defining requirements and processes for delegation of MCO functions, including obtaining written agreements that specify delegated functions; conducting pre-delegation assessments, ongoing monitoring, and annual assessments; and implementing corrective action plans for delegate performance that does not meet the MCO's expectations. In addition to policies, the MCOs have oversight monitoring tools that assist with ongoing monitoring and annual oversight activities.

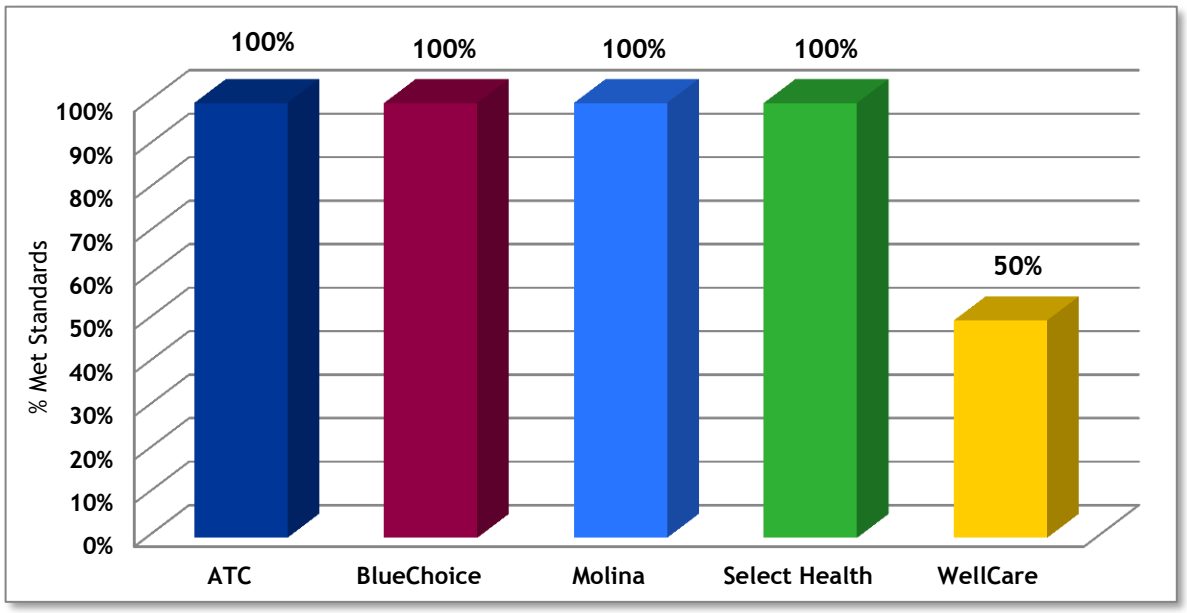
The review of Delegation confirmed policies guide staff in the initial delegation process, monitoring, and annual oversight functions; delegation agreements include contract requirements; tools exist that assist with oversight functions; corrective action plans are developed to address substandard performance; and oversight is conducted by the plans annually.

ATC, BlueChoice, Molina, and Select Health received "Met" scores for 100% of the standards for Delegation review. CCME made recommendations to BlueChoice about replacing the Excluded Parties List System (EPLS) reference to reflect the System for Award Management (SAM) in its *Delegation Agreement* template. CCME also recommended that Molina revise the *Credentialing Program Policy* to indicate pre-delegation assessments are conducted for NCQA-accredited entities.

WellCare received one score of "Partially Met" due to CCME's findings that WellCare did not verify ownership disclosure forms for out-of-state providers are being collected and did not review delegate credentialing files to validate delegate compliance with all credentialing requirements.

Each plan's percentage of "Met" scores is demonstrated in *Figure 13, Delegation*.

Figure 13: Delegation



A comparison of the plans' scores for the standards in the Delegation section is illustrated in *Table 10, Delegation Comparative Data*.

Table 10: Delegation Comparative Data

Standard	ATC	BlueChoice	Molina	Select Health	WellCare
Delegation					
The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions	Met	Met	Met	Met	Met
The MCO conducts oversight of all delegated functions sufficient to insure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions	Met	Met	Met	Met	Partially Met

Strengths

- All of the MCOs are in compliance with requirements for written delegation agreements.

Weaknesses

- CCME's findings indicate WellCare does not perform all required delegation oversight activities, including credentialing file reviews and verifying ownership disclosure forms are collected for out-of-state providers.

Recommendations

- WellCare should update processes to include all delegation oversight activities, including the collection of ownership disclosure forms for out-of-state providers and credentialing file review.

G. State-Mandated Services

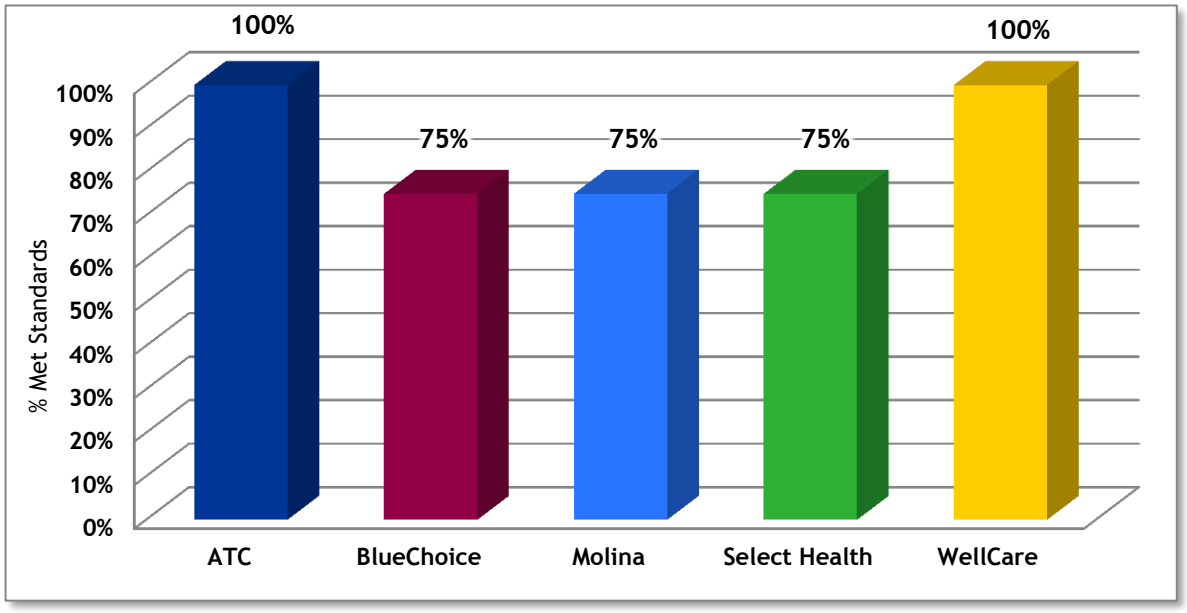
CCME's review of the State-Mandated Services section focuses on ensuring the plans provide core benefits required by the SCDHHS Contract and that each of the MCOs adequately addresses deficiencies identified in its previous EQR.

Each health plan provides the required core benefits and has established EPSDT Programs to ensure mandated services are provided to members from birth through the month of their 21st birthday. The plans monitor provider compliance with the provision of EPSDT services, including provision of appropriate immunizations, via claims analysis and periodic medical record reviews.

ATC and WellCare addressed all deficiencies identified in the previous review; however, BlueChoice, Molina, and Select Health have uncorrected deficiencies. Each of the MCOs submitted quality improvement plans to address identified deficiencies and all were accepted. CCMEs findings indicate that for BlueChoice, Molina, and Select Health, all quality improvement plan correction items were not implemented.

Each plan's percentage of "Met" scores is demonstrated in *Figure 14, State-Mandated*.

Figure 14: State-Mandated



A comparison of the plans' scores for the standards in the State-Mandated Services section is illustrated in *Table 11, State-Mandated Comparative Data*.

Table 11: State-Mandated Comparative Data

Standard	ATC	BlueChoice	Molina	Select Health	WellCare
State-Mandated Services					
The MCO tracks provider compliance with administering required immunizations	Met	Met	Met	Met	Met
Performing EPSDTs/Well Care	Met	Met	Met	Met	Met
Core benefits provided by the MCO include all those specified by the contract	Met	Met	Met	Met	Met
The MCO addresses deficiencies identified in previous independent external quality reviews	Met	Not Met	Not Met	Not Met	Met

Weaknesses

- Three of the MCOs did not fully implement all corrections of deficiencies identified in the previous EQR.

Recommendations

- MCOs should fully implement all corrections of deficiencies identified in current and prior EQRs.

H. SC Solutions

The review of Administration for Solutions included the review of policies and procedures, leadership and staffing, compliance, program integrity, data security, confidentiality, and personnel file review. The Board of Directors, Executive Committee, and Chief Medical Director provide leadership at the corporate level. Solutions Executive Director, Thomas McGee, oversees business activities and service delivery for participants in South Carolina.

Solutions has added additional staffing in response to a significant increase in membership. A Compliance Officer is on staff; however, activities normally conducted in the Compliance Committee are being conducted in the QM Committee. Solutions does not have a Compliance Committee. New policies are needed to address certain processes and some policies require revision to include specific South Carolina contract requirements. Data security, confidentiality training, and business ethics and conduct are well-documented in policy and the *Employee Handbook*. CCME found that personnel files lacked updated driver license and driver insurance amounts required by Solutions.

CCME reviewed documents and reference materials used by the plan to educate contracted providers. Solutions does not have a policy that addresses initial and ongoing provider education. In addition, educational materials such as the *Solutions Provider Manual*, an *MCCW Provider Training* presentation, and information on the plan website contain outdated or inconsistent information.

Solutions' QI program is provided at the corporate level thru Community Health Solutions of America. *Community Health Solutions' Strategic Quality Plan for 2017* was provided as evidence of a quality improvement program description. This program description is not specific to Solutions, and it is unclear what activities or sections of the program description apply to Solutions. The 2016 and 2017 work plans lacked quarterly updates and the implementation or completion dates for each activity.

The Care Coordination/Case Management section of the review included review of policies and other documentation of Solutions Care Coordination/Case Management Program as well as file review. Policies address most care coordination and case

management requirements and Solutions processes to meet those requirements; however, CCME noted errors, discrepancies, and omissions of information for specific Care coordination requirements are detailed within the policies and other documentation. Solutions has not developed a contractually-required written policy addressing back-up service provision plan. CCME recommends developing a written Care Coordination/Case Management program description that provides an overall description of the Care Coordination/Case Management program and addresses information missing from policies such as the program structure, lines of responsibility, and accountability.

Review of care coordination files confirmed that Solutions conducts appropriate care coordination and case management functions to support member health and functioning. CCME noted isolated issues with missing documentation in the files reviewed, but these omissions do not appear to represent widespread process issues.

An overview of the scores for Solutions is illustrated in *Table 12, Solutions Scores by Review Section*

Table 12: Solutions Scores by Review Section

Standard	Solutions
ADMINISTRATION/ORGANIZATION ACTIVITIES	
The organization has policies and procedures that are organized, reviewed, and available to staff	Met
The organization's infrastructure complies with contract requirements. At a minimum, this includes designated staff performing the following activities: Administrative oversight of day-to-day activities of the organization and available per contract requirements	Met
Care coordination and enhanced case management	Met
Provider services and education	Met
Quality assurance	Met
Designated compliance officer	Met
The organization formulates and acts within policies and procedures which meet contractual requirements for verification of qualifications and screening of employees. At a minimum, includes the following: Criminal background checks are conducted on all potential employees	Met
Verification of nursing licensure and license status	Met
The organization screens all employees and subcontractors monthly to determine if they have been excluded from participation in state or federal programs	Met
Care Coordinators meet all contract requirements	Met

Standard	Solutions
Staff are independent of the service delivery system and are not a provider of other services which could be incorporated into a Participant's Care Coordination Plan	Met
Employee personnel files demonstrate the organization complies with contract and policy requirements	Partially Met
The Organization has established a governing body or Advisory Board	Met
The responsibility, authority, and relationships between the governing body, the organization, and network providers are defined	Met
The organization carries out all activities and responsibilities required by the contract, including but not limited to: The organization is available by phone during normal business hours 8:30 am to 5:00 pm Monday through Friday	Partially Met
The organization adheres to contract requirements for holidays and closed days	Met
The organization has a process to conduct onsite supervisory visits within 5 days of receiving a request from SCDHHS	Partially Met
Organization and participant records are retained and available as required by the contract	Met
Participant program education materials are written in a clear and understandable manner, and are available in alternate formats and translations for prevalent non-English languages	Met
Processes are in place to ensure care coordination services are available statewide	Met
The organization formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health and information privacy	Met
The organization maintains an appropriate fiscal accounting system	Met
The organization has policies, procedures and/or processes in place for addressing data security	Met
The organization has policies, procedures and/or processes in place for addressing system and information security and access management	Met
The organization has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented	Met
The organization has policies/procedures in place designed to guard against fraud, waste, and abuse, and including the following: Written policies, procedures, and standards of conduct comply with federal and state standards and regulations	Met
A compliance committee that is accountable to senior management	Met
Employee education and training that includes education on the False Claims Act, if applicable	Met
Effective lines of communication between the compliance officer and the organization employees, subcontractors, and providers	Partially Met

Standard	Solutions
Enforcement of standards through well-publicized disciplinary guidelines	Met
Provisions for internal monitoring and auditing	Met
Provisions for prompt response to detected offenses and development of corrective action initiatives	Met
A system for training and education for the Compliance Officer, senior management, and employees	Met
Processes for immediate reporting of any suspicion or knowledge of fraud and abuse	Met
The organization reports immediately any suspicion or knowledge of fraud or abuse	Met
PROVIDER SERVICES	
The organization formulates and acts within policies and procedures related to initial and ongoing education of providers	Not Met
Initial provider education includes: Organization structure, operations, and goals	Met
Provider responsibilities and procedures for obtaining authorization from the state for services and referrals, as needed	Met
Medical record documentation requirements, handling, availability, retention, and confidentiality	Met
How to access language interpretation services	Not Met
The organization provides ongoing education to providers regarding changes and/or additions to its programs, practices, standards, policies and procedures	Partially Met
QUALITY IMPROVEMENT	
The organization formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to participants	Met
An annual QI work plan is in place which includes activities to be conducted, follow up of any previous activities where appropriate, timeframe for implementation and completion, and the person(s) responsible for the activity	Partially Met
The organization has established a committee charged with oversight of the QI program, with clearly delineated responsibilities	Met
The QI Committee meets at regular intervals	Met
Minutes are maintained that document proceedings of the QI Committee	Met
A written summary and assessment of the effectiveness of the QI program for the year is prepared annually	Met
The annual report of the QI program is submitted to the QI Committee	Met

Standard	Solutions
Care Coordination/Case Management	
The organization formulates and acts within written policies and procedures and/or a program description that describe its care coordination and case management programs	Met
Policies and procedures and/or the program description address the following: Structure of the program	Partially Met
Lines of responsibility and accountability	Partially Met
Goals and objectives of Care Coordination/Case Management	Met
Intake and assessment processes for Care Coordination/Case Management	Partially Met
Provision of required information to participants at the time of enrollment	Met
Minimum standards for phone contacts, in-home visits, and physician/nurse plan oversight as applicable	Partially Met
Processes to develop, implement, coordinate, and monitor individual care coordination plan with the participant/caregivers and the PCP	Met
Maintain clear and open communication with the participant's caregiver/parents. This must include written documentation of caregiver/parent participation in and understanding of the Care Coordination Plan that is dated and signed by the care coordinator	Met
Process to regularly update and evaluate the care coordination plan on an ongoing basis.	Met
Processes for following up with participants admitted to the hospital and actively participate in discharge planning	Partially Met
A process to report any suspected abuse, neglect, or exploitation of a participant	Partially Met
Back-up service provision plan to ensure that the Participant receives the authorized care coordination services and a process to notify SCDHHS if services cannot be provided	Partially Met
The organization provides a written, formal evaluation of the Service Plan to SCDHHS every 6 months or upon request	Met
File review confirms the organization conducts Care Coordination and Case Management functions as required by the contract	Met

Strengths

- Confidentiality and HIPAA training is conducted annually and defined in policy.
- Solutions has a thorough business continuity plan (*Continuity of Operations Plan*) and has demonstrated its ability to handle and recover from disasters while providing continuity of care.

- The *Solutions Provider Manual* contains detailed information regarding medical record confidentiality, documentation, and retention timeframes.
- Care advocates are clinicians who act as "clinical extenders" for case managers.
- Solutions holds monthly care management meetings for staff training, information sharing, etc.

Weaknesses

- Solutions does not have a Compliance Committee.
- Personnel files do not have information related to current driver licenses and required amounts of automobile insurance.
- Plan materials and the website have outdated information such as incorrect phone numbers or numbers out of service, inaccurate hours of operation, and inconsistent address information. Some policies do not include SC-specific requirements.
- Solutions does not provide information about how to access services for the hearing/speech impaired.
- Training of providers on the *False Claims Act* or FWA is not documented.
- Solutions does not have a policy that addresses initial and ongoing provider education.
- The *Solutions Provider Manual* and training materials do not reference any information about how providers can assist non-English speaking members that need language assistance.
- Provider educational materials include the *Solutions Provider Manual*, an *MCCW Provider Training* presentation, and information on the SC Solutions website; however, it does not appear the information is current. The *Solutions Provider Manual* is dated 2015 and contains outdated information; the website displays provider newsletters from 2012 and has a non-functioning Document Distribution section; and there is inconsistent benefit information between the website and the *MCCW Provider Training* presentation.
- *Community Health Solutions' Strategic Quality Plan for 2017* was provided as evidence of a quality improvement program description. This program description was not specific to Solutions. It is unclear to CCME what activities or sections of the program description applied to Solutions.
- It is unclear if the date included on the work plan represents the implementation or the completion dates for each activity. The quarterly updates are not always included and some activities noted as on-going on the 2016 work plan were not included on the 2017 work plan.

- The *Annual Report: Quality and Performance Improvement Calendar Year 2016* summarized the quality initiatives for 2016. CCME found it difficult to determine which activities are applicable to Solutions.
- A formal, written Care Coordination/Case Management program description has not been developed and policies lack complete information on the Care Coordination/Case Management Program, including program structure, lines of responsibility, and accountability.
- Discrepancies in the Care Coordination/Case Management goals/objectives, preadmission screening initiation and completion timeframes, and the timing of various visit types are noted in various documents.
- Team Conferences are conducted only for Part A members; however, policy implies Team Conferences are conducted for all members.
- Processes for discharge planning when a member is hospitalized are not addressed in policy.
- Solutions has not developed a contractually-required written process to address back - up service provision plans.
- Policies address reporting suspected neglect or abuse of a member to Adult Protective Services, but do not address reporting to Child Protective Services if the client is less than 18 years old.

Recommendations

- Update plan materials, policies, and the website to reflect current information.
- Establish a Compliance Committee.
- Provide information about accessing services for the hearing impaired/speech impaired.
- Document in a policy or process Solutions process for receiving and conducting supervisory visits.
- The quality improvement program description and program evaluation should include details related to Solutions.
- The QI work plans should include all quality improvement activities underway. Also, verify the work plans contain implementation and completion dates for each activity and implement processes that ensure they are updated frequently.

I. Coordinated and Integrated Care Organization Annual Review

SCDHHS contracted with CCME to conduct a benchmark review of the Coordinated and Integrated Care Organizations (CICOs) to determine readiness for assuming additional responsibility and authority over the Home and Community Based Services (HCBS) for the Medicare and Medicaid population. To conduct the review, CCME requested data from SCDHHS to establish the minimum number of providers needed in each county to assess network adequacy. CCME received data that included the projected population size per county, active authorizations per county, the number of active providers for each service in each of the counties, and the current enrollment in the Healthy Connections Prime Program by county. Using this data, CCME assumed that the provider level received in the data is covering the population's demand for each service adequately. The calculation process used to determine the minimums is defined below.

Calculation Process

From the data provided, CCME determined the distinct counts of:

- Active providers across each service and county
- Potential population for each county based only on the South Carolina Community Choices Waiver Program data
- Current service authorizations for each county and service

A ratio between the projected population counts and active provider (PPAP) counts for each service and county combination was calculated (PPAP = A/C). The results are rounded to the tenth decimal place.

The mean, or average, and the 75th percentile of the PPAP across counties are both calculated for each service. Mean Service Ratio (MSR) and 75PR, respectively.

The MSR is used to divide the services into four service tiers based on bin sizing of the ratio:

Table 13: Four Tier Bin Size

Tier	Projected Population
1	MSR >= 60
2	40 <= MSR < 60
3	20 <= MSR < 40
4	MSR < 20

The average of the 75PR across each service tier is calculated and rounded to the nearest tenth place. This is the Minimum Approximation Ratio (MAR).

Current Minimums: For each county and service the MAR is used to calculate the unadjusted provider minimum (UPM) for that county/service combination (UPM = D/MAR).

The following rules are used to adjust the minimum number of providers:

- To enable as much choice as possible, if the UPM < 3, then the Adjusted Provider Minimum (APM) is set to three.
- If the APM is more than the number of providers in the county, then the minimum is set to the number of providers.
- If the current population is zero, then the APM is set to three by default since the unadjusted provider minimum is zero and falls in the first rule above.

With advice from SCDHHS, the services are placed in categories and assigned a tier level. *Table 14, Service Tiers and Categories,* shows the service categories and tier assigned.

Table 14: Service Tiers and Categories

Tiers	Service Categories
1	• Home Delivered Meals • Telemonitoring
2	• Adult Day Health
3	• Case Management • Respite
4	• Personal Care • Personal Emergency Response System (PERS) • Supplies

CCME initiated the benchmark reviews in January, April, and July of 2016. CCME notified each CICO that it would conduct the benchmark reviews and requested the following desk materials:

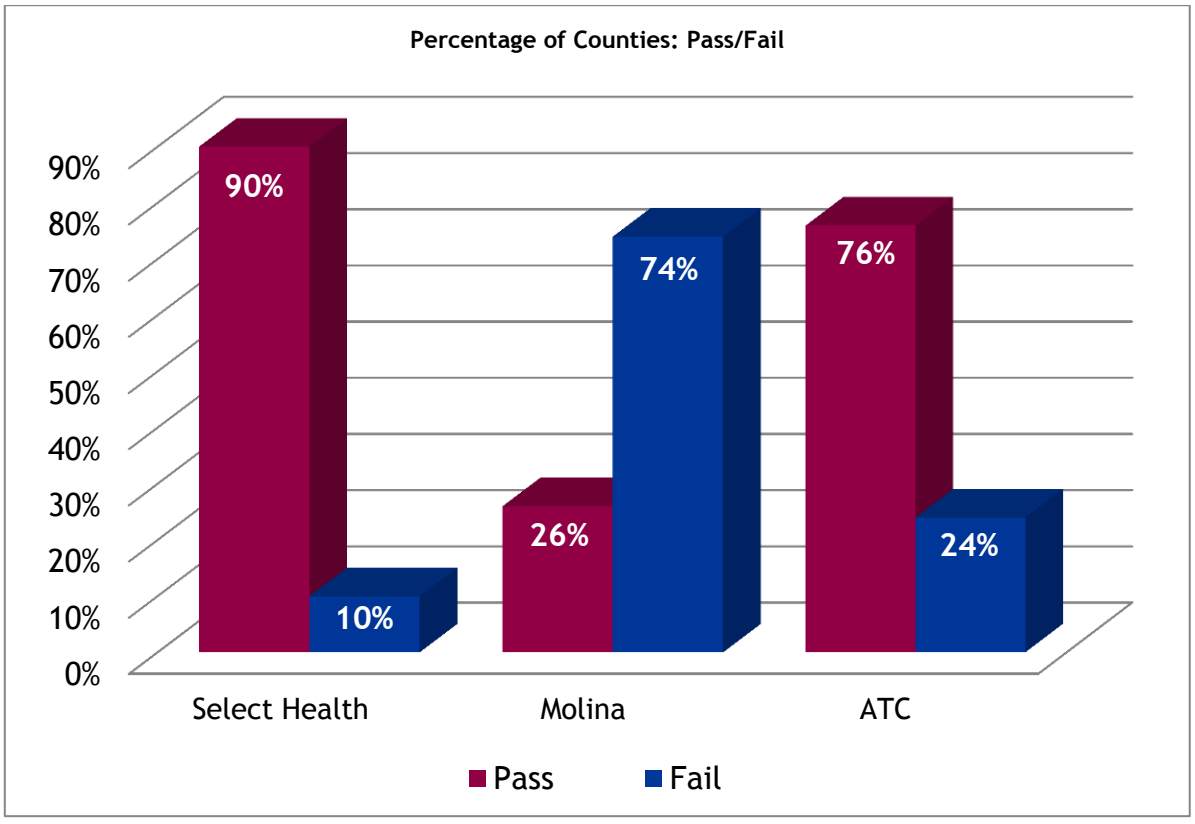
- A complete list of all contracted HCBS providers currently in their networks, including contracted reimbursement rates.
- Copies of all executed contracts.

- Documentation of all service and provider network planning activities (i.e., geographic assessments, provider network assessments, enrollee demographic studies, population needs assessments) that support the adequacy of the HCBS provider base.
- Copies of all policies, procedures, processes and standard operating procedures for the HCBS Program.
- A description of the HCBS Program, including the program structure, lines of authority, responsibilities, staffing levels, timeliness guidelines, and related documentation.

Results of Network Adequacy Review Overview

The final adequacy reports were submitted to SCDHHS in July 2016. After submitting the adequacy report to SCDHHS, CCME assigned a category of "Pass" or "Fail" to each county for each of the three Plans. The percentage of counties falling into the "Pass" and "Fail" categories are displayed in *Figure 15, Network Adequacy Review Results*.

Figure 15: Network Adequacy Review Results



Note: Counties with zero enrollees were not included in pass/fail percentage calculations.

Table 15 illustrates the network adequacy problematic areas for each plan.

Table 15: Areas of Improvement for Network Adequacy

Plan	Telemonitoring	Adult Day Health Care	Respite	Home Delivered Meals	Case Management
ATC	✓		✓	✓	✓
Molina	✓		✓	✓	
Select Health	✓	✓			

Strengths

- Supplies, Personal Care, and PERS service categories are provided adequately to enrollees.

Weaknesses

- All plans had issues providing telemonitoring services.

Recommendations

- Continue the process of enhancing the provision of telemonitoring, adult day health care, respite care, home delivered meals, and case management to enrollees by locating providers within the respective service areas.

FINDINGS SUMMARY

The CCME's findings of the annual EQRs conducted for contract year 2016–2017 confirm that all of the plans achieved improvements in the overall "Met" scores for Member Services area. ATC and WellCare demonstrated improvements in all areas reviewed.

Table 16, Annual Review Comparisons, reflects the total percentage of standards scored as "Met" for the 2016 through 2017 EQR. The percentages highlighted in green indicate an improvement over the prior review findings. Items highlighted in yellow represent a reduction in the prior review findings. This is the first annual review for Solutions, so only the 2017 data is reflected in this table. Areas reviewed for the MCOs that are not applicable for Solutions is noted as Not Applicable (N/A).

Table 16: Annual Review Comparisons

SECTION	ATC		BLUECHOICE		MOLINA		SOLUTIONS	SELECT HEALTH		WELLCARE	
	2015	2016	2016	2017	2016	2017	2017	2015	2016	2015	2016
Administration	100%	100%	100%	93.9%	90.91%	91%	89%	94.12%	100%	96.97%	97%
Provider Services	89.33%	95%	92%	92%	86.67%	92%	50%	92.75%	89%	85.33%	94%
Member Services	89.19%	95%	86.49%	94.6%	83.78%	95%	NA	88.89%	92%	89.19%	95%
Quality Improvement	100%	100%	93.33%	100%	86.67%	87%	86%	93.33%	93%	86.67%	100%
Utilization Management*	76.32%	97%	84.21%	92.1%	92.11%	87%	53%	71.79%	89%	81.58%	92%
Delegation	50%	100%	100%	100%	100%	100%	NA	0%	100%	0%	50%
State-Mandated Services	100%	100%	100%	75%	75%	75%	NA	75%	75%	75%	100%

*Care Coordination/Case Management for Solutions